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Understanding professional partnerships and non-hierarchical organisations

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Executive Summary

Background

Organisations such as professional partnerships, co-operatives and similar non-hierarchical organisations (NHOs) play a larger role in health care than is usually recognised. For example general practices (professional partnerships) handle over 80% of patients' first contacts with the NHS. Co-operatives provide much out-of-hours primary care. The role of such organisations might well increase as more diverse providers enter the NHS. The structure of these organisations is partly or entirely democratic. Unlike corporations and most public sector organisations they are accountable to their working members, or to service users, and allocate leadership roles by election or taking turns. Fewer than one percent of published research studies examine these forms of organisation. The studies that do exist raise two main questions. Are these types of organisation 'efficient', compared to hierarchies? And do they tend to 'degenerate' over time, reverting to hierarchy?

Aims

The aim of this research was to strengthen the evidence base for decisions about what kinds of partnerships and NHOs the NHS should incorporate or commission. We aimed to answer the research questions:

1) What are the goals (explicit and implicit) of such organisations and why/how are they established?
2) What is the nature of the governance and incentive arrangements that are placed on these organisations from external bodies? Is there an effective form of regulation, and if so what is th e nature of this?
3) What are the structures and internal organisational arrangements of non-hierarchical organisations and partnerships? How are professional partnerships and non-hierarchical organisations co-ordinated, and what makes for a successful co-ordination strategy?
4) What are the key elements to the internal management of such organisations?
5) How do professionals within such organisations interact with each other and how do they regulate themselves?
6) How do such forms of organisation impact on securing professional engagement?
7) Clinical workloads, job satisfaction and morale?

8) The development of innovative practice?
9) Process: How do such forms of organisation impact on:
    a) Clinical quality and development of best practice?
    b) Adherence to external performance targets?
    c) The cost-effectiveness of service provision?
    d) Patient outcomes/experiences?

Methods

Two methods were used to achieve these aims. A systematic review of existing research was used both to bring together existing explanations of how the distinctive organisational structures found in professional partnerships and non-hierarchical organisations operate, what conditions cause them to 'degenerate' and what conditions enable them to operate effectively. To test these explanations we firstly reviewed and re-used the empirical findings contained in the research we had reviewed. Secondly, we made and compared new case studies of twelve organisations: three general practices; three professional partnerships outside the NHS; three health cooperatives (two English, one American); and the cooperatives outside the NHS. We then combined our findings about patterns across these case studies with previously published findings; and then compared the combined findings with some earlier theories and predictions about professional partnerships and non-hierarchical organisations.

Results

The goals of partnerships and NHOs are typically to secure for members and partners and income no worse than prevailing market rates; produce a quality of work befitting their members' occupational status: to provide services for a particular locality: to break even (not maximise external shareholder profits); and to realise other values, including cooperation or professional values for their own sake.

The main external governance mechanisms are contract and regulation. Contracts work most effectively when their terms are specific, unambiguous, legitimate (in the providers' eyes) and strongly incentivised. To preserve NHOs' organisational structures against the weakening ('degeneration') of members' or partners' democratic control of the organisation, alternatives to financing by external shareholders are required and limiting the proportion of (non-voting) salaried employees.

Partnership and NHO organisational structures essentially take either of two forms: a direct democracy of small workplace teams (which can articulated in multiple layers for controlling a large organisation); or a representative democracy in which the workforce elects the top, but not middle, managers. Optionally there may be a supporting infrastructure of employed staff.

Successful coordination relies primarily on concertive control. Members or partners monitor each others' work and through peer pressure prevent shirking.

Key elements to the internal management of partnerships and provider NHOS they are concertive control; legitimation of collective decisions by appeal either to an organisational culture or to technical knowledge; and as a last resort expulsion of non-compliant members. The internal management of consumer NHOs is undertaken largely by employed managers. Smaller-scale organisations (e.g. workplace team, general practice) can operate through informal, direct democracy, taking decisions by consensus. Larger organisations can operate through indirect democracy whereby members elect a top manager (or a board) with similar powers to their corporate or public sector counterparts. Indirect democracy appears better suited than direct democracy when the organisation's work is not intrinsically rewarding (e.g. is laborious, monotonous, done at inconvenient times or places, inflexible). Three main causes of 'degeneration' are over-reliance on supplementary hired labour, dependence on corporate sources of capital funding, and managerial 'capture' of the organisation.

Professionals within such organisations interact and regulate themselves largely through direct democracy, peer pressure and the use of technical knowledge as described above, but in larger partnerships a distinct stratum of manager-professionals may emerge. Professional engagement in these organisations is promoted by high pay; by the organisation's decisions and activity being important for the professional's work taken as a whole; by enabling contact with fellow-professionals; and by providing a well-organised support infrastructure. Production processes in NHOs and partnerships tend to produce an upward shift in the expertise and skills of their members and partners, which tends to satisfy members' and partners' intrinsic (i.e. non-instrumental, non-financial) motivations to work. In that respect they tend to increase workload, and add a managerial dimension. The forms of innovation which they favour are innovation through extensive replication, vertical integration, diversification and 're-engineering', provided that these innovations sustain the quality of work which the members or partners undertake and maintain the members' or partners' centrality to the productive process. NHOs and partnerships generally prefer to develop and market services and products on the basis of quality rather than price. The combination of evidence-based knowledge, incentives and concertive control appears to raise clinical quality. There is sometimes tension between requirement to break even and the goal of raising quality of work. User participation mechanisms may have merit as a means of representing users in NHO and partnership governance but the character of user experience appears was more effectively monitored and managed by developing systems for routine data collection on that point. Because of their founding goals and membership, NHOs and partnerships were active implementers of evidence-based medicine. External competition provided a discipline to control costs, EBM a discipline for clinical effectiveness. On

balance, economic theorists' predictions that NHOs and partnerships are economically inefficient and unsustainable were not supported by the evidence. In the NHS both partnerships and NHOs are demonstrably capable of close adherence to external performance targets when these targets are clear, specific, legitimate (to the providers), incentivised and compliance (or not) is transparent.

Conclusions

Because professional partnerships and non-hierarchical organisations tend to pursue goals which are more closely aligned to NHS objectives than those of corporations, there are likely to be advantages in commissioning them as NHS providers. Then, commissioners are likely to be less dependent on incentive schemes and adroitly-formulated contracts to align the provider's goals artificially with those of the NHS. Because these organisations compete on quality rather than price, and try to maintain their members' incomes and working conditions, they may be at a price disadvantage against corporate providers unless steps be taken to ensure a 'level playing field'. One such step is to let longer-term contracts than the one or two years duration of some present contracts. Another would be to arrange public sources of loan capital for non-corporate providers. Our American case study suggests that users could play a much bigger part in commissioner governance than was customary in English PCTs, but also that governance by users is difficult to sustain. We also identify suggest further research needs, including the need for head-to-head comparisons of professional partnerships, non-hierarchical organisations, corporations and public bodies as service providers.

1 Policy context

When particular organisations are made responsible for implementing a given health policy, their organisational structure constrains what policy outcomes result (1). Policy-makers and researchers generally take for granted that organisations have a hierarchical structure, an assumption which the focus and content of most published organisational research appears to confirm, as does the character of the organisations usually the most visible in the mass media and in public policy debates.

Yet organisations with apparently non-hierarchical structures also exist, including professional partnerships, co-operatives, mutuals, charities and other 'third sector' organisations. Although less visible, these organisations are also important to health policy, organisation and management for several reasons. These organisations play a larger role in the health sector, and more widely, than is usually recognised. Knowledge of how they work is therefore indispensable for understanding how health systems work. In the form of general practices, professional partnerships handle about 90% of patient contacts with the NHS (2). An understanding of their organisational structures and their practical implications is therefore necessary to the process of attempting to implement health policy through them. Non-hierarchical organisations (NHOs) also challenge by example some conventional assumptions about organisation and management, not least the new public management. If indeed organisation members can make decisions in egalitarian, collaborative ways, what use then remains for managers? If consumers or the public can through democratic or participative mechanisms exercise governance over organisations, what need remains for shareholders or public bodies to do so?

The present study therefore investigates the relationships between these non-hierarchical organisational structures and the health policy outcomes which they are liable to produce in health systems such as the English NHS, so as to explore what the specific organisational benefits - and disbenefits - of non-hierarchical organisational structures are. In doing so it focuses on professional partnerships and non-hierarchical organisations (NHOs).

Professional partnerships have a role in the health system to which UK policy-makers and NHS managers have given increasing attention since 1990. The 2004 GMS contract regards the partnership itself, not the individual GP, as the contractor with whom the NHS deals. Legislation and new regulations in 1997 and 2004 widened the range of partnerships involved, opening the NHS to new forms (nurse-led partnerships, partnerships with non-medical partners). Practice-based commissioning is another move in this direction. The recent white paper Equity and Excellence (3) anticipates the transfer of most of the commissioning of NHS hospital care to consortia of general practices, a policy intended to give

these partnerships a dominant role as the patient's agent in selecting, financing and monitoring secondary care.

Recent policy changes in primary care have also made more evident the existing and potential role of NHOs in the NHS. On one hand the 2004 GMS contract caused substantial contraction in the number of GP cooperatives. Against this, the policy of provider diversification is being applied to primary care, creating opportunity for new forms of NHO to enter, or to develop from within, the NHS. Since 2004 English health policy has promoted 'Social Enterprise' forms of healthcare provider structure. The Secretary of State for Health published through the Social Enterprise Coalition a statement (4) on the advantages of social enterprises. The DH has established a social enterprise unit. These policy-makers have however defined the term 'social enterprise' broadly rather than sharply, as the concurrent policy of provider diversification and 'pluralism' might lead one to expect. In particular, policy-makers count NHS Foundation Trusts which have a clearly bureaucratic and therefore hierarchical organisational structure as 'social enterprises' (5). (All bureaucracies are by definition hierarchical but not all hierarchies are bureaucracies.) The same applies to those Primary Care Trusts which, as policy-makers now recommend, (reconstitute themselves as social enterprises providing managerial support to GP commissioning consortia. However social enterprises with other types of organisational structure also exist, including examples with egalitarian, democratic organisation structures, enlisting both paid and volunteer labour. To contrast the latter categories with hierarchical organisational structures such those of Foundation Trusts we use the term 'non-hierarchical organisation'.

These changes have made timely, and relevant to current health policy and management, the aim of by exploring forms of partnership and of non-hierarchical organisational structure that NHS organisations might wish to commission, collaborate with or adopt, initially on an experimental basis.

1.1 Professional partnerships

Professional partnerships are found in most health systems, especially as primary medical care providers. (The most important exceptions are the Nordic health systems which rely mainly on salaried polyclinic doctors.) partnerships have also been a way of organising groups of hospital doctors, for instance in the Netherlands until recently. English publications for the later nineteenth century mention group practices. The first published account of them in the USA dates from 1919 (6).

However it has not always proved easy to reconcile this type of organisational structure with free, universal health services. Problems of access have been one reason, illustrated by the recent history of GP dentistry in England. The NHS contract negotiated with general dental practitioners (GDPs) proved too expensive in the opinion of the Department of Health, who subsequently re-negotiated it on less favourable terms, alienating many GDPs and compromising access to NHS dental care in some

parts of England. To increase their incomes, partnerships often try to combine private work with mainstream health system work. For example German Kassenärzte nowadays generally aim to have at least 10%, often 20%, of private patients, in order to maintain a viable partnership income. The independence of partnerships can at times create difficulties, from the state's standpoint, of governance and manageability, resulting in part from the inscrutability of their clinical practice (the Shipman case is the extreme example) although evidence-basing of clinical practice is palliating this difficulty; and in part from the fact that external governance over them is exercised largely by the blunt instrument of contract.

Before 1947 medical GP partnerships in Britain had three main sources of income. The experience of two of these sources (coloured for decades afterwards many English GPs' subsequent attitudes and beliefs about how primary medical care should be funded and organised. In industrial, especially mining, areas friendly societies and trades unions often contracted or employed GPs to provide medical care for their members and, at times, their members' families. Some of these organisations gained a reputation for heavy, unrewarding workloads and and ungenerous pay. Local government had employed doctors since the days of, and in, workhouses and asylums besides departments of public health and (later) municipal acute hospitals, acquiring a similar reputation (7). These memories long sustained GP distaste for salaried employment with government bodies.

With the 1997 Primary Care Act that pattern began to change, starting a diversification of the organisational structures of professional partnerships (above all, general medical partnerships) in terms of:

1. Ownership: a small number (in 2009, still probably below 20) nurse-owned general practices have come into being, with the organisational structure of a partnership but with the partners being all or mostly nurses, or having a nurse as senior partner.
2. Membership: a small (but unknown) number of mixed-membership general practices have appeared whose partners include nurses, pharmacists, allied health professionals and managers besides GPs.
3. Service profile, with the addition of CBT and other therapies, minor surgical procedures, and (less commonly) on-site diagnostic testing and 'alternative' healthcare. A substantial minority of GPs have become GPs with special interests in such diseases as diabetes and CHD.
4. Staffing profile, with the spread of salaried GPs employed by the partnership as partners (it may be) in a collegial but not a legal sense or a structural sense as they are not co-owners of the practice. The long-established trend of recruiting 'ancillary' staff began with practice nurses but has continued to include out-posted CHS and

social work staff, nurse practitioners and other staff necessary who deliver the wider service profile described above.

5. Federation of separate partnerships into a network centred on one of them as a GP-led health centre or on a PCT-run primary care facility as in the London 'polysystems'.
6. Commissioning role through the practice based commissioning system (and previously through GP fundholding), although general practices' uptake of PBC is reportedly uneven (8) with only a minority of general practices very active commissioners. As noted above, policy-makers now plan a large expansion of GP commissioning.

These developments have legal and regulatory implications, for instance in regard to the ownership of assets, audit and EU competition requirements, but also managerial and commissioning implications. The more detailed and comprehensive targets in the 2004 GP contract and the Quality and Outcomes Framework (QOF) have also required increasingly sophisticated management of these partnerships to meet external or 'agency' targets (9).

Alternatives to the professional partnership structure for organising primary health care have also appeared, including:

1. NHS Direct, which despite planned modifications will essentially continue.
2. NHS Plus (OH services).
3. Case management, when the case managers are CHS staff or social workers rather than general practice partners or employees (10).
4. Walk-in centres, including experiments with primary care provision within, or in separate units adjunctive to, hospital accident and emergency departments.
5. Pharmacy-based health care, for instance medicines utilisation reviews or simple consultations, by pharmacists (11).
6. PCTMS services, usually in a general practice-like format but involving a de facto nationalisation of former partnerships with a PCT directly employing primary care doctors.
7. Corporations employing salaried GPs.

Concomitantly, PCTs and other health care commissioners have developed service commissioning methods (above all APMS) expressly not limited to professional partnerships.

1.2 Non-hierarchical organisations: a dual provenance

The other organisational form on which UK economic policy has focused since the 19th century is the shareholder-owned private limited liability

company (PLC or 'corporation', the latter not to be confused with the recently-created entity of 'public benefit corporation').

Corporations' managers are in law explicitly and exclusively the agents of the firm's owners i.e. shareholders. The shareholders have decision-making votes and divide any profits in proportion to the size of their shareholdings. Because of the corporation's organisational structure, in particular its ownership, its managers generally interpret their prime responsibility and objectives as being to maximise the (profits distributed to shareholders and hence the value of the shareholders' collective property (reflected in share price) . The internal organisational structure of a corporation is almost always bureaucratic, therefore hierarchical. The corporation is a prototype against which other organisational structures can readily be contrasted and defined.

A variety of contrasting organisational structures have in the last decade regained policy salience in the UK, promoted from (on both left and right of the political spectrum.

1.2.1 Co-operativism and mutualism

The alleged merits and defects of the corporation have remained controversial policy questions over the last 150 years. The alleged defects have motivated the invention and construction of alternative types of organisational structure.

In health policy a standard criticism of corporate provision and financing health services has been that, more powerfully than any others, such organisational structures produce 'inverse care' outcomes (12). People with health problems are those least likely to be able to pay out-of-pocket for health care or buy health insurance affordably, or at all, from corporate insurers (for the very reason that they are likely to use their insurance). Nowadays the US health system with its high proportion of under-insured and non-insured people (13) is the example usually cited but until late nineteenth century European health systems were much same. The mutualist response was to set up non-corporate cooperatives or mutuals to provide affordable sickness insurance for income replacement when ill, payment for health services when required, or both. Depending on the country, the origins of these mutuals lay either in workplace-based organisations (e.g. trades union-based sick funds in Britain (14)); sick-funds for occupational groups (for example in Germany), religious or similar charities (e.g. the large Catholic sick funds in France, Belgium), or organisations purely of patients (found in the USA to this day). In Britain such organisations, evaluated in the Beveridge report (15), became largely redundant when the NHS was founded and switched from funding basic to funding supplementary private health care (e.g. Nuffield; BUPA health insurance). English health policy documents often mention 'consumerism' as an influence upon health system development (e.g. (16)) but less often define it clearly. For present purposes, 'consumerism' can be defined as

activity (typically by NHOs) aiming on consumers' behalf to intervene in, or even resolve, the alleged conflicts between corporate and consumer interests (17). Briefly, the early consumerist organisations were attempting to contest corporations' tendencies to wasteful product design. They meant corporations' tendencies, in pursuit of profit, to design consumer goods with planned obsolescence (18); over-packaging; with no (e.g. bottled water) or negative (e.g. tobacco) value to the informed consumer; forced upgrades (e.g. some commercial software); over-specification for purpose (e.g. 4x4 cars for suburban drivers); single use only (disposables); and adulteration. Misinformation of consumers was a corollary. Beginning with campaigns for smoking control (19), the 'new' public health movement (20) has also advanced more narrowly focused, but also more strongly evidenced-based, views of these kinds. Elements of the consumerist movement attributed these defects to the incentives for maximising sales and output arising from the corporate organisational structure.

It followed that any countervailing organisations should have different organisational structures. In Britain the two commonest options were to set up campaigning organisations such as the Consumers Association (a company limited by guarantee: see below); and mutual aid organisations to finance goods and services not otherwise affordable to their members. Those which developed to fund pre-NHS hospital care are now almost forgotten (14) but a well-developed mutual building society movement still exists despite about 60% of it demutualising in the 1980s and 1990s. For the supply side of the economy, a large and both intellectually and politically influential literature has made three main criticisms of the effects of the corporation's hierarchical organisational structure: that it produces exploitation of the workforce (21) ; it impoverishes the quality of working life (22); and it is undemocratic (for a recent overview see (23)). Besides the formation of trades unions and political parties (beyond the remit of the present project) the organisational structures produced in response have included co-determination (Mitbestimmung: widespread in mainland Europe), trades union action, shop-floor programmes and works councils within existing corporations; and producer co-operatives as an organisational structure intended to supplant completely that of the corporation. Producer cooperatives have included organisations (combined consumer-producer cooperatives) for consumers to self-provide specific goods and services, ranging from foodstuffs through sport to information (CABs etc.) and including some health services (e.g. for reproductive health, hospice care) which in England the NHS was tardy or equivocal about supplying.

Outside the NHS, Cook et al. (24) show that 'mutuals' (consumer co-operatives, building societies, mutual insurers and friendly societies) have a total membership of around 19 million people (compared with about 11 million share holders), making them a considerable economic sector in their own right. NHOs range from banks to football clubs to cooperatives. In healthcare:

There are about 35,000 TSOs [third sector organisations] in England providing health and social care services valued at £12bn, while a further 1,600 plan to enter in the near future... Most provide services in the fields of mental health, disability, learning difficulties, or long term care. (25)

It is sometimes argued that NHOs are as, or more, efficient (26-28), entrepreneurial and user-responsive than large private or public firms, are a form of collective self-help and have a proven ability to innovate in forms of service provision.

English health policy has favoured setting up NHS Foundation Trusts with a 'social enterprise' (SE) structure 'modelled on co-operative and mutual traditions' (5). The imitation does not however extend to having a non-hierarchical organisational structure, although a local public membership and an appointed supervisory board are superimposed on an organisational structure which otherwise strongly resembles that of the NHS trusts established in 1991. Neither does it appear in the small minority of Primary Care Trusts (PCTs) which have separated groups of their former community health service staff (e.g. nurses, allied health professionals) into separate organisations (e.g. Central Surrey Health), much as local authorities have 'spun off' their former employees into social enterprises which, say, run residential care or sell building and engineering work back to the council (e.g. CorMaC). As part of the NHS Next Stage Review ('Darzi report') introduced, the Department of Health introduced

a "right to request" for Primary Care Trust (PCT) staff to set up social enterprises (SEs) to deliver services. The Boards of all 152 PCTs in England will be obliged to consider such requests and, if approved, support the development of the social enterprise and ultimately award it a contract for up to five years to deliver those services.

www.dh.gov.uk/en/Procurementandproposals/Tenders/Informationaboutprocess/DH_10003

A 'Pathfinder' programme was set up to support and help fund 25 social enterprises, selected from over 300 applicants (29), which were then publicised as worked examples to encourage others to do likewise. All social enterprises have legally binding contracts with NHS or other statutory commissioners. There is no doubt, however, that the primary care out-of-hours cooperatives which flourished in the early 1990s, and of which many large examples continue to operative, are essentially non-hierarchical organisational structures. They too tend to regard themselves as social enterprises and work under contract to PCTs.

The default position of English health policy (the 'Fitness for Purpose' policy) is now that PCTs should contract out primary and community care services rather than provide them directly. Ministers have pronounced that the use of social enterprises for such purposes could expand further. From 2005, the new commissioning framework (30) was intended to accommodate social enterprises as permissible providers of NHS primary and community care (31,32). A Social Enterprises Investment Fund was set up to enable third sector organisations to invest in preparing themselves to provide health care for the NHS. Both Personal Medical Services and the Alternative

Provider Medical Services contractual frameworks have been used to enable third sector organisations to provide NHS services under contract. Recent commissioning policy expressly includes the option to commission local voluntary groups, registered charities and cooperatives besides foundations trusts and 'social enterprises' (31); and for PCTs to reconstitute themselves as social enterprises (3).

In sum, current policy foresees a growing role for social enterprises in NHS provision and NHOs are one variant of social enterprise.

1.2.2 Types of non-hierarchical organisation in England

How current English policy defines the term 'social enterprise' is not altogether clear. The term covers, but is certainly not limited to, consumer-controlled and worker-controlled cooperatives. It expressly includes provider organisations 'spun off' from former public bodies including PCTs. The category overlaps but is not equivalent to that of a 'charity' (see below). Similarly the category overlaps with that of the voluntary organisation. It can also include 'not-for-profit' organisations, such as the insurance arm of BUPA, which differ from commercial firms mainly in not distributing profits to shareholders.

The legal system is however generally clearer than policy documents on these points. At present English law differentiates the following types of legal personality for companies (P. Allen, personal correspondence).

1. Charities are often but wrongly regarded as a kind of organisational structure. To be a charity is a legal status which different types of organisational structure can attain provided their goals include at least one of those listed in the Charities Act 2006 (which include the advancement of health). Charities may not distribute their assets to their members. For-profit corporations may not be charities.
2. Unincorporated associations, which have no legal personality distinct from their individual members. Individual members therefore personally sign any contracts, own property and incur debts instead of the association. In countries with English-style legal systems partnerships fall into this category. They are defined as agreements between two or more persons to undertake an activity in common, with each partner being jointly and severally responsible for the other partners' decisions and liabilities relating to that activity (33). These liabilities are unlimited.
3. Companies limited by guarantee have no share capital. Instead, their members guarantee a fixed sum of money which is their maximum liability should the company fail.
4. Corporations (in the economic sense used above; the term also has technical meanings in law) are companies limited by shares. Their members fund the company and are allocated votes in it s controlling

meetings and profits in proportion to their share ownership. Their maximum liability should the company fail is that their shares become worthless and non-refundable.

5. Community Interest Companies (CICs) are a limited liability company introduced by the Companies (Audit, Investigations and Community Enterprise) Act 2004 specifically as a legal personality for social enterprises. Companies limited by guarantee ((3) above) and corporations ((4) above) can become CICs, but only if they have primarily social objectives or serve a community interest. Their assets may only be used for these purposes but up to 35% of their profits may be distributed to shareholders.
6. Industrial and Provident Societies (IPSs) are limited liability organisations governed by specific legislation (e.g. the Industrial and Provident Societies Acts 1965-2002, Cooperatives and Community Benefit Societies Act 2003). They are governed on the principle of one member, one vote. Members pay a subscription (which need not be equal for all members). Should the company fail they get only this initial payment back and no further assets. There are variants:
   (a) A cooperative or mutual pursuing only its members' benefit. Profits may be distributed to members, but not in proportion to size of shareholding.
   (b) A society which pursues a wider public benefit, not just its members' interests. It may not distribute profits to its members and can chose to impose an 'asset lock', meaning that should the company fail its assets can only pass to another asset locked organisation (e.g. a charity or CIC).

Some legal systems admit 'limited liability partnerships' in which partners are not personally liable for other partners' errors or debts if they had no part in committing them, although the partnership does remain jointly liable. Whilst partnerships are widespread amongst knowledge-workers ((33,34), this connection is a contingent relationship not a defining structural characteristic, although it does raise the empirical question of why such a pattern has emerged.

1.3 Policy relevance of the study

Consequently the study of professional partnerships and non-hierarchical organisations is of policy relevance for the following reasons:

1) Partnerships remain the dominant organisational structure for the provision of primary medical and dental care. Reforms to them however continue. For one, the basis on which they recruit patients is about to change from a catchment to a subscriber model, raising questions about the likely implications for existing partnerships. The 'engagement' of independent GPs with health policy and NHS

management is always necessary for the effective coordination of primary care services and for managing hospital referrals, but this engagement is likely to become if anything more important should the anticipated cuts in NHS budgets materialise (35).

2) Federated (networked) and (hierarchical) polyclinics have been mooted as alternative organisational structures for primary care provision. Conceivably these new primary health centres could also be structured as cooperatives. Indeed at least one is already designated to be operated by an existing out-of-hours cooperative. As described below some of these cooperatives are attempting to broaden their activities into other areas of primary care.

3) Elements of primary, community and social care already are, and further types of health and health-related services readily could be, provided by cooperatives or other NHOs in future.

The commissioning of secondary care will largely be undertaken by consortia of general practices, nearly all of which are professional partnerships. Managerial infrastructure for this activity may be provided by, among others, social enterprises including social enterprises converted from PCTs and, conceivably, NHOs such as cooperatives (3). Three policy and management questions therefore arise:

1) Under what circumstances might it be preferable to commission a cooperative or NHO provider rather than an NHS provider or a commercial provider? That is, under which circumstances and which types of service are NHOs well adapted to provide for the NHS?

2) Does the commissioning and management of NHOs appear to require a specific approach, different to the case of other providers?

In recent years the community services provider arms of PCTs have in a few cases been 'spun off' as social enterprises, but hierarchically organised ones. Would another way of re-establishing these services as separate organisations be to establish them as a cooperative or similar NHO?

2 Theoretical and research framework

2.1 Research context

The present study builds on an SDO review of research relating organisational structures to policy outcomes. It stated:

> Particularly under-researched are the structures of non-hierarchical organisations such as GP co-operatives, professional partnerships, and the provision of NHS services in collaboration with voluntary bodies and local government. (36), p.12

That study implied a contingency approach (37) to future research about partnerships and NHOs, i.e. research which investigates how partnership and NHOs vary in origins (environment), structures, processes and outcomes, and how different variants are adapted (or maladapted) for different policy purposes and environments. This approach appears especially relevant to such diverse organisations as the terms 'PP' and 'NHO' cover.

Many studies equate 'organisation' with 'hierarchy' or 'bureaucracy' although network theory is now eroding that assumption. Organisational researchers largely neglect partnerships and NHOs. Of 14314 initial entries in the database for the aforementioned SDO review only 315 (2%) related to partnerships or NHOs. Of them only about a sixth compared theory and evidence.

Although partnerships are one of the oldest forms of organisational structure pre-dating by several centuries the limited-liability company (33) empirical accounts of how they form, function and fail are relatively sparse. The findings and pattern of these studies are described (and referenced) more fully below but briefly they tend to concentrate on accountancy and legal, and to a lesser extent architectural, partnerships in the UK, USA and Canada. There are a few studies of the inner workings of general practice partnerships, including the effect of their internal organisation upon clinical processes or intermediate outcomes (38-40) but most studies of general practice presuppose the organisational structure rather than analyse it. A few studies describe marketing (41-43), innovation ((44) and planning (26) techniques for partnerships.

Empirical studies of NHOs tend to concentrate on a few well-known examples: the Mondragon cooperatives, worker-controlled enterprises in the former Yugoslavia, US agriculture and kibbutzim. There are a few studies of English (45) and Scots (46) GP cooperatives. Histories exist of the cooperative movement and its antecedents (47) but most are tangential to present purposes. An important group of studies analyse how far the employment of supplementary wage-labour or external capital leads

cooperatives to 'degenerate' into corporations. Studies of former communist countries (48,49) describe how NHOs can emerge ex nihilo and also succumb, reporting what policy environments produce either effect. Recent policy developments in England have encouraged fresh reviews of research into not-for-profit organisations (50) and social enterprises (51), but NHOs and partnerships are only subsets of these categories. Research has focused more on the complementary bureaucratic subset.

Theoretical accounts of how partnerships and NHOs form, function and sometimes fail are equally meagre. Institutional economics explains organisational structures in terms of what kinds of the transactions the organisation undertakes; their scale and frequency, whether opportunism or trust develops, the distribution of knowledge, and how much competition or contestability there is in the organisation's market environment (52). However 'new' institutional economists concentrate on hierarchies and markets, for whose sake Williamson (53) expressly avoided considering partnerships and NHOs, although Hansmann (54) proposed a theory of contractual failure to explain why partnerships and NHOs emerge. Micro-economic models of cooperatives have been made, Vanek's (55) being perhaps the most influential. Elements of the economics of clubs (56) have also been applied to partnerships and cooperatives. Beginning with Michels' (57) 'iron law of oligarchy', a few researchers of various disciplines have proposed explanations of why large democratic organisations 'degenerate' into oligarchies.

We next synthesise some existing theory about NHOs and partnerships into a framework which will then guide a systematic review of existing empirical research into those organisations and the presentation of new primary data about a sample of them.

2.2 Organisational environment, structure, process and 'fit'

As our highest-level theoretical framework we adapt one used by the SDO's systematic review of the research literature on organisational structure and performance (36). Homologous frameworks have also been used by other researchers into health systems and organisation (e.g. (58)) and an SDO study of networks. A common framework aids comparison between more concrete (middle-level) theories and empirical findings.

This theoretical framework describes the sets of relationships between four sets of factors: organisational environment, organisational structure, core productive process and the policy outcomes thereof. Recognising the complexity of the relationships between (and within) these four sets of factors, the theoretical framework concentrates on theorising three main relationships:

1) Between environment and organisational structure

2) Between organisational structure and core productive processes How organisation's core productive processes produce policy outcomes.

3) How organisation's core productive processes produce policy outcomes.

'Core process' means the set of techniques, by which an organisation attempts to produce whatever goods, services or other outcomes it is that organisation's goal to produce. In health care settings, this core process includes not only interventions at biological level, but the collaborative practical activities (which deliver those interventions. Together the biological and the organisational elements comprise a model of care, with its characteristic variables of access to care, utilisation of services, continuity of care, clinician activity and competence (59), evidence base and patient and carer inputs. 'Process' in this sense refers to a technical, not (purely organisational, process.

In partnerships, non-hierarchical and indeed any organisation the overriding purpose of managerial processes is to mobilise, manage and reform the core working processes which actually produce whatever outcomes ('effect', 'functions', 'performance', 'success') an organisation achieves (60). In summary, an organisation's environment gives rise to the organisation itself and its goals, to pursue which a core process is required, and to operate that an organisation structure is created. The goals motivate and this structure operates a core process which literally produces outcomes (which may or not satisfy the original goals). Environment, the organisational goals arising from it and the organisational structure can thus be thought of as a set of initial conditions; process and outcome as what emerge from these initial conditions. Contingency theory explains organisational structure in terms of the type of tasks that the organisation undertakes, what technology these tasks require and the everyday working processes involved (e.g. (61,62)). For an organisation to be effective its structure must 'fit' its environment and its process of production, and the latter must 'fit' the intended outcomes.

What makes NHOs and professional partnerships feasible alternatives to public or to corporate bureaucracies is that in at least certain cases more than one organisational structure is capable of operating a given core process. For it is obviously false to postulate a rigid one-to-one correspondence between type of core process and organisational structure. Even organisations operating near-identical technologies (e.g. car manufacturing, railways, indeed hospitals) seldom use identical organisational structures. When a provider co-operative supersedes a failed corporation (e.g. Triumph in 1980s) it initially inherits and operates the same core process as before, but to different ends.

Nevertheless a process of production does impose some organisational constraints. To operate a core process requires physical means of production equipment, raw and intermediate materials, decisions, information and feedback; and specific working times, places and sequences of activities because of the interdependence of stages of work (e.g.

production line workers must all start and stop work at the same time). It also requires methods for accommodating any uncertainties or disruptions in the work (63,64). The physical processes also constrain the number of people necessary to operate them and the skills required (e.g. classroom teachers must be literate). Hence use of a given technology necessitates using one of a specific range of compatible organisational structures. In many cases (although there are apparent exceptions such as armies) that range includes both hierarchical and non-hierarchical structures. We therefore describe the relationship between core process (technology) and organisational structure as one of mutual constraint, interpreting 'fit' and 'determines' accordingly.

If in practice these conditions are not met, a partnership, NHO or any other must adjust at least one of the four elements (environment, structure, process, outcomes) back into 'fit'. During the formation of an organisations its members adopt an organisational structure which they believe suffices to operate the core working process which they also adopt. Practical experience may expose these beliefs as false; the core process does not (indeed, cannot) produce the intended outcomes. Indeed the more fully a misconceived core process is implemented, the less likely it becomes that the intended outcomes will be achieved. Also, unexpected outcomes may appear besides the intended ones, indeed negate the intended ones (e.g. if case management increases case-finding on a scale that more than compensates for reduced admissions per hundred patients (65)). (Other events (technical innovations; external resource availability; natural disasters; policy changes; cultural or demographic shifts) may also disrupt the 'fit' between environment, structure, process and outcomes. Then the structure, processes or both may be modified or exchanged for others (perhaps over-reacting: Sorge and van Witteloostuijn (66) argue that organisational change occurs more often than necessary. If an organisation's core process fails to produce its intended outcomes the members have (the option either to alter the core process they use (e.g. alter equipment, inputs, techniques) or to revise their objectives to match what the core process can produce. If the organisation's structure proves unsuitable for operating the core process, the NHO members have again two options. They might to alter the core process of production to one that the existing organisational structure can operate, but then risk failing to fulfil their original objectives and having to renegotiate them (67). Alternatively they can adjust the organisational structure (e.g. skill mix, information systems, means of coordinating the core process) and try again. Any such adaptations must however remain broadly compatible with members' original motives for joining the NHO (68). The penalty for not making a compatible set of the above adjustments is continued failure, leading to loss of the original membership and resources (but perhaps also the gain of members who prefer the new regime to the old). Thus a non-hierarchical (and indeed any other) organisation selects members who are content with its de facto activities and the values they represent (69).

An organisation's structure, managerial practices and environment thus co-evolve, with environment having in most cases the larger influence (70). Successive working practices and belief systems become 'sedimented' over time (71), making development of the organisation's structure path-dependent; the after-effects of history determine an organisation's future development (72).

Thus organisational structure affects organisational outcomes (73,74). Our next step is to synthesise existing theory about professional partnerships and NHOs so as to elaborate how the above framework might apply to those kinds of organisations specifically.

2.3 Environment

2.3.1 Membership and formation

To understand what goals professional partnerships and NHOs have, and why, requires an account of who sets these organisations up and why. That is, an account of these organisations' origins in a given social environment.

Institutional economics raises the question of when, when a group of individuals wish collective to undertake a productive activity ('core process') an organisation emerges rather than a network or a Coaseian market of bilateral contracts (75). However with a few exceptions, above all Hansmann's work (54), transaction cost theory mostly, indeed deliberately (52), focuses on the formation of corporations. It also begs the most important question for a study such as this one by presupposing either that organisations are formed by individuals who already relate through a market or, still more question-begging, that markets are (so to speak) a 'state of nature' from which all other forms of economic organisation are either derivatives or, to speak normatively, degenerations. Historical evidence (e.g. (76,77)) refutes these empirical assumptions.

Instead we assume that NHOs originate 'from below' from individual producers or consumers who believe they through such an organisation they can satisfy certain of their already-existing personal motivations more effectively (or at all) by collaborating (78) This explanation requires a theory of individual motivation to work. Without accepting every elaboration which Herzberg (79) and Maslow (80) made, the assumption of a hierarchy of motivations ('needs') founded upon the most imperative and 'basic' ones (81) has a basis in psychological theory. In descending order of imperativeness, motivations relevant to the foundation of professional partnerships and NHOs are to secure:

1) A certain minimum income, whether in kind, in money (55) or a mixture. We assume that individuals (as opposed to certain organisations) mostly seek a target (82,83) ('satisfice') rather than maximise money income. Simon (84) argued that this applies even to top corporate managers.

2) A safe physical environment for work, minimising the monotony, laboriousness (surveillance and danger of work, and enabling the incidental benefits of social networking and informal relationships (85).

3) Activities and exercising skills which their occupational cultures or disciplines accord high status and value to (86), including working to 'professional' standards of production i.e. quality standards defined a priori in technical or normative 'disciplinary' terms.

4) Such scope as the technology allows for learning and other forms of self-development such as 'enablement' (the opposite of de-skilling) (87) or increasing autonomy and discretion at work (88).

5) Pursuit of pre-existing non-economic (e.g. political or religious values) that the members bring into the organisation when it forms (89,90).

On that assumption, insofar as the goals of a partnership or NHOs came to reflect its members' motivations, those goals would include the above, perhaps even follow the above ranking.

2.3.2 Why non-hierarchical or partnership?

A partnership or a NHO forms when three conditions all hold: other forms of organisations fail to meet the above needs or (in economic terms) maximise their members' welfare compared with other forms of organisation (91,92,68); collective action is nonetheless necessary to meet these needs; and none of the individuals who propose to act collectively has the power to subordinate the others within a new hierarchy.

We do not assume that public and commercial bureaucracies oppose the aims listed above. Rather, they cannot satisfy those aims when:

1. No such organisation exists, in the cases of goods or services which are either unprofitable to sell, controversial (e.g. birth control in the 1920s) or of low prestige or desert in the eyes of state or professional interests (93). In healthcare, groups of patients or carers who nonetheless want such goods or services must then either establish a producer organisation (e.g. Marie Stopes clinics, hospices, HIV/AIDs charities in the 1990s) because they cannot achieve these ends privately (94), or establish a consumer NHO to obtain these services from elsewhere.

2. Working conditions or activities of existing providers fail to meet the needs of those who go on to found a partnership or NHO, perhaps because the founders were in a weak bargaining position. Doctors (for example) may perceive a clash between a prospective employer's and their profession's values (87).

3. A producer did exist but is closing down (95) Its work-force take over the enterprise to 'rescue' their livelihood (96-98) (e.g. Triumph motorcycles in the 1980s (99)).

Thus on the supply side of an economy the two main patterns of NHO formation are either from takeover of an existing productive enterprise or creation ex nihilo. It is obvious why collective action is necessary for operating a large core process such as a factory production-line, but less obvious what the benefits of working collectively are in professional activities such as medicine or law which to a large extent are individualised, handicraft activities performed mainly through one-to-one interactions between professional and client. At one extreme an 'atomised' partnership of such professionals might offer no benefit beyond office-sharing (69). However Hansmann (54,100) proposed that partnerships and NHOs rather than corporations emerge when the costs of contracting between members is higher than those of risk-bearing through trusting each other. Forming or joining an organisation largely removes the transaction costs of allocating (other) costs and income between the members or partners (6). Co-operatives produce greater welfare for their members than other forms of organising by giving their members control over a vertically integrated process of production and jointly exploiting economies of scale which they separately could not (68). By their nature partnerships can emerge only on the supply side of an economy. They allow the partners to share risks and obtain a given income for less effort (101,102). A professional joining an existing partnership gains access to its ready-made reputation for quality of work (103)and avoids having to build up a clientele from scratch. For clients who are in a position of information asymmetry vis-a-vis professionals, exclusionary regulation is one way of establishing a 'brand name' which implicitly signals to clients what quality of service they can expect. However general practice is the medical specialty where this asymmetry is least (6).

On the demand side, consumer NHOs form to obtain goods and services for their members on better terms (of price, information and quality) than otherwise obtainable in a market (104,100,105) or quasi-market. In Britain one instance is when patients or carers set up appeals around cause celebre patients whom the NHS is alleged to have 'let down'. Consumer NHOs also redress information (asymmetries between providers and consumers (100), and increase consumers' collective bargaining power against producers. Cooperatives which retail direct to consumers either re-sell goods at lower than market prices (newer consumer cooperatives) or sell goods at market prices but afterwards redistribute any profits to their members in proportion to their members' spending with the co-operative ('Rochdale pioneer' or 'patronage' model) (106). Besides credit for purchases, consumer credit unions provide households with a means of managing income fluctuations (107), avoiding the higher interest charges of commercial or of illegal lenders.

The third condition for a partnership or NHO to emerge is that none of the prospective members can compel the others to join as her subordinate employees (i.e. establish a hierarchy). Members and partners make broadly equal inputs, have equal rights to participation in decision-making and gain broadly equal benefits from collaborating. Hence cooperatives or

partnerships emerge in production activities which require little initial plant or equipment (or money-capital to buy them), for instance handicrafts or activities whose main input is knowledge rather than physical materials; or when a group can take over control of a large productive process (factory, laboratory) without having to find the initial capital themselves. Nowadays the most common way in which the start-up condition is met, is by having members pay a standard subscription e.g. a money fee (106) or, in an association of independent producers or of consumers, agree to buy a minimum level of goods or services from the NHO (68).

2.3.3 External dependencies and governance

To operate its core productive process a partnership or NHO needs to obtain externally whichever inputs its own members cannot supply. Together these internal and external inputs have to be sufficient cover all requirements of the core process. Put in financial terms, the partnership or NHO has to break even (68). For this purpose an NHO can besides its members' contributions draw externally upon market sales, private donations or the state, whether as a quasi-bureaucratic donor or commissioner in a quasi-market (108). By imposing conditions for supplying resources, donors and commissioners create external, second-order incentives and objectives for the recipient organisation (109). What effects external incentives have upon an NHO depends upon what is measured by the incentive-payer, hence upon what is transparent to the external funders (69). (What is measured is what the incentive in practice attaches to.) Such media of control can be applied and exercised, however, only to the extent that the activity which the external body wishes to influence is transparent (visible) to it. The internal structure of the recipient organisation then has to adapt - if its members allow - to these requirements.

Law and regulation provide the repertoire of property rights and forms of legal personality which are available for creating and structuring an NHO. (Those available under English law are noted above (ch.1)). Law and regulation are what essentially differentiate a professional partnership from a cooperative or mutual. A 'full' (rather than 'semi-' (110)) profession has legal or regulatory accountability for quality of practice and restriction of entry, giving members of the profession de facto property rights over the regulated work which enable their members to pursue (within the regulations) their own preferred modes of practice. These property rights are reflected, as explained below (ch.2s4), in the 'hybrid' organisational structure of a partnership.

Neo-institutionalist theory emphasises that the beliefs which members apply in founding and operating NHOs pre-date that organisation. The new organisation is socially embedded in a legal and regulatory system, a social 'culture' with particular 'values' and in social, occupational and organisational networks (111-114). Pinnington and Morris (115) point out that coercive, normative and mimetic pressures to conform with

occupational norms are especially strong in the professions. The putatively purely technical 'discipline' of medicine also establishes a relationship of 'governmentality' between doctor and patient, doctor and managers, and doctor and her professional seniors (116).

2.3.4 Goals

From this complex of individual motivations, resource endowments and the wider, embedding sets of ideologies, laws and other institutions are formed the organisation's goals (objectives). partnerships and NHOs are founded to give governance of the organisation to different interests than control public or commercial bureaucracies, and concomitantly to pursue different goals. One would therefore expect their substantive goals to differ from those of public and commercial bureaucracies. One would expect the goals of a partnership to be the aggregate of the motivations and interests of its individual members (115) and the same reasoning applies to NHOs. Consequently one would expect these goals in broad terms to be:

1. To obtain for their members a specified level of livelihood or access to a predefined set of goods or services.
2. The sequence of formation outlined above presupposes that the individuals are closely enough connected, either by geographical and social proximity or, nowadays, through communications media to make it practical for them to collaborate. For this reason, and insofar as an NHO originated from the failure of an earlier enterprise, or its founding members were linked by some prior affiliation (e.g. ethnicity, residence, local activism), one would expect its goals to include the provision of service or benefit to a local community defined geographically (89).

NHOs and partnerships undertaking productive activity would also aim to realise:

1. What their members regarded as good working conditions (117).
2. Work activity and its products which their members regarded as being of good technical quality befitting their occupation.
3. Learning and other forms of self-development.
4. Other non-economic values that the members subscribe to (69,118), including workplace democracy for its own sake (97).

Policy changes which are in their own interests and those of like-minded organisations. There is no reason why a single organisation cannot pursue many different goals provided the members believe (perhaps rightly) that all these goals are compatible.

Insofar as consumer cooperatives or mutuals arise in order to obtain unprofitable, controversial or low-status goods or services for their members, they would develop two kinds of goal:

1. Obtaining goods, not by producing the missing goods or services themselves but either by purchasing the service members or reimbursing members when they buy it.
2. Campaign goals of inducing legislators to alter laws or regulations to induce firms producing consumer goods and services to alter their business models and marketing mix in consumers' favour; and to implement consumers' existing legal or contractual rights (e.g. truthful information about products; redress for bad products).

Some analyses (e.g. (68)) assume that partnerships, NHOs or their members are profit-maximisers but in this context 'profit' is a slippery and ambiguous concept. After the immediate costs of production are paid, possible uses of the residual income include:

1. Payment to members or partners for their own work.
2. Extending the organisation's productive capacity. (One might say 'investment' were that term not so often tied to the idea of increasing profits in sense (4) below.)
3. Contingency funds saved as 'working capital' or to tide the organisation over income or cost fluctuations (69).
4. 'Normal profits' (which labour process theorists (e.g. Braverman (60)) regard as rentier payments) distributed to non-working external shareholders. This is the standard everyday sense of the term 'profit'.
5. Payments to (other) external rentiers (e.g. banks, owners of intellectual property). To producers these payments appear as costs, but to their recipients as profits.

Non-hierarchical organisations and partnerships whose purpose is to maintain their members' livelihoods attempt to obtain profits in senses (1) (2) and (3), not (4) or (5). Of these, sense (1) is fundamental. Profit-making in senses (2) and (3) is only a means to that end. Because the aim of (1) is members' personal consumption, because aim (2) is technically defined' and because (3) are costs to minimise so far as is prudent, 'obtain' usually means 'satisfice' not 'maximise'. Volunteer organisations have no need for profit-making in sense (1), only 'profits' of types (2) and (3). Furthermore, whilst purposes (2) and (3) can be funded from operating profits, they can instead be funded by, say, member subscriptions or donations (106). Because the requirements to finance technical development and (if it cannot be avoided) pay interest and similar charges are determinate, finite costs to a NHO, 'profit'-making in senses (3) and (5) amounts only to a requirement to break even in the long term. Expansion of productive capacity also amounts to a requirement to break even in the long term, except where NHO members regard the expansion of their organisation's activities as an end in itself. If NHO members take a fixed money income, that is 'satisfice' rather than 'maximise' money income, the same applies to 'profit'-making in sense (1). In contrast, whilst a

corporation must also break even if it is to survive, its fundamental aim is to maximise profits in sense (4) above.

This approach towards profits, besides the other social values which partnerships and NHOs tend to have, implies a different competitive strategy than the one a corporation would usually pursue in order to maximise profit. The latter implies that the ideal position for a commercial firm is to be a monopolist. That implies a strategy of maximising market share and removing competitors from the market when possible, either by take-over or 'predatory' competition. If that cannot be done the next best strategy is to create a de facto monopoly through such methods as branding, 'first mover' advantages and retention of intellectual property. A satisficing organisation, in contrast, has the strategy of securing a large enough market to break even whilst providing a predefined quality of product and a predefined level of income for its members. What matters then is the absolute size of its own market, not market share. Its competitive strategy is therefore oriented towards obtaining that size of market. That condition met, its strategy towards other organisations can afford to be collaborative and open rather than predatory or even competitive. The non-economic values which professional partnerships subscribe to 'what they regard as 'high' standards of work are more likely to produce convergence (on those standards) than differentiation as a marketing strategy.

Having negotiated a set of goals the need arises for a core process which, members think, will achieve them. For a partnership or for an organisation taking over an existing failed corporation or public body, the intended core process is predefined as the work of which the members or partners already do or are credentialised to do respectively. Having selected a core process, it then becomes necessary to allocate and coordinate the work among the people who are going to operate it. Hence these people have to create an organisational structure (even if they do not conceive of it in those terms) which they think will sustain that collaboration (70).

2.4 Structure

2.4.1 Modes of democracy

Professional partnerships and NHOs form to coordinate the work of more-or-less equal members who cannot coercively or hierarchically control one another. In these circumstances the obvious - though not the only conceivable (119) - organisational structure to adopt is some form of democracy (120,121). Small organisations can adopt directly democratic, relational control and decision making. The members' or partners' meeting, reaching decisions by consensus, is the fundamental decision-making and coordinating structure in a direct democracy. Major decisions, task allocation and work monitoring are taken by the members collectively through discussion. Posts of responsibility can be allocated to -and removed

from - members or partners by rotation (122), sortition, consensus or vote. Consensus-building is likely to be the preferred form of democratic decision-making among professional partners (103). With consensus or voting the criterion for selecting a leader may be for proposing lines of activity with which most of the members agree or because she has accumulated resources of value to the organisation. Leaders may often be identified, especially in professional partnerships, as those members or partners either with special skills or interests or status (e.g. a founding member, long-serving member, technically accomplished member) (123). These leaders may emerge through everyday work or organisational structures specifically for selecting and controlling them may develop. The close cooperation that relational democracy involves creates trust and wider information-sharing, which, Abzug and Phelps (124) say, make collaborative partnerships achieve their goals more fully than purely office-sharing 'atomistic' partnerships.

Such structures require organisations, or sub-units of organisations, small enough for the members all to participate in a single meeting and to be familiar with each other's work (74); hence, to have relatively homogeneous memberships and core activities (33). Professional partnerships do however generally satisfy these conditions.

In theory even large organisations can also operate by direct democracy. Representatives are directly elected at sub-unit workplace meetings on the above pattern, through which members select (and recall) delegates to higher-level bodies. This 'upward delegation' structure can be replicated layer upon layer (to encompass the largest organisation.

In what might be called a 'representative' mode of democracy managers are elected by ballot for a fixed term of office or even indefinitely (until they leave the organisation). Ballots can be made across an organisation of any size, with members or partners choosing between policy options framed by the candidates.

Whichever mode of democracy be adopted, a large organisation will typically have a coordinating body ('board', 'committee', 'council', 'executive') accountable to the electing members or partners not to shareholders or the state. Its members are elected on the basis of their authority or legitimacy in the eyes of the workforce and to reflect their electors' interests. They may but need not be full time paid officials. A precondition for democratic control is to make information about the internal management of the organisation transparently available to its members or partners (117). (In hierarchies such information is in effect the property of top managers.).

2.4.2 Implementation

It then remains to implement the elected managers' decisions. As noted, a first requirement for this is a degree of internal transparency about

members' or partners' work within the organisation. Members each contribute to the work of the NHO and in return expect others to do so. On the basis of an a priori economic model, Espinosa and Macho-Stadler (125) predict that a major problem with equal profit distribution in partnerships is verification of members' contributions to profits. The benefits of reducing shirking are shared between all partners (126) yet this is a challenge because creative and intellectual pursuits are more difficult to monitor than mechanical, repetitive tasks (102). Healthcare furthermore is a stochastic process. Different doctors may treat patients exactly the same way but not all patients may react to the treatment in the same way, making it difficult (and perhaps unfair) to attribute output categorically to a particular partner. One solution is to rely upon trust is based on professional ethics, which are said to make individuals reluctant to monitor one another on a professional basis for the purposes of output measurement (127), but the less they monitor each other the more likely is a decline in overall partnership or team performance. Therefore an important coordination task for partnerships and NHOs is to establish some form of individual output measurement (128) or other system enabling each member to scrutinise the others' work (69).

Should free-riding or non-compliance be detected, members or partners have a graduated set of methods available for changing the behaviour of free-riding or non-compliant colleagues (129). In ascending order of severity of the sanctions attached the methods are:

1. Technical persuasion (authority) based upon scientific knowledge (in health care, formalised guidelines and clinical pathways). This sanction assumes that the member under-performs through not knowing how to do his job.

2. Appeals to ideology and shared values (normative assumptions) (67), a collective 'culture' (130-132) which acts as a 'private law' within an organisation (133).

3. Concertive Control, the collegial application of informal relational sanctions (134) through, initially, informal 'advice' or feed-back (123) such as the 'quiet word' among professionals (135) or, more powerfully, peer approval and disapproval (136), perhaps reinforced through social contacts outside work (118). Rather than expend their own 'social capital', however, members recruit a third party as intermediary to deal with 'free-riding' colleagues (67). Using evidence taken from a hierarchy rather rather than an NHO, Barker describes how through informal peer control:

> the organization's members developed a system of value-based normative rules that controlled their actions more powerfully and completely than the former [i.e. hierarchical bureaucratic] system. (136): p.408

But if on the contrary mutual scrutiny repeatedly verifies that a person competently contributes full her share, trust develops among the members or partners (137). Hence:

The partnership form of governance is better suited to the management of professionals than the private or public corporation as it (1) uses more efficient (collegial) control processes and (2) provides superior incentives for expert individuals to share proprietary knowledge. (33)

4. Allocation of resources, whether personal income or benefits in kind (holidays, study opportunities, convenient working hours, preferred area of work).
5. Expulsion. Game theory often assumes that 'clubs' (in particular consumer clubs) can exclude potential members in order to prevent 'overcrowding' of the services offered (94). Expulsion is the equivalent to demotion or dismissal in a hierarchy.

Partnerships and NHOs nevertheless retain some structural similarities with bureaucracies. A division between work and private activity and income is maintained. Accepting favours, 'presents' or bribes is forbidden in partnerships and NHOs as it is in bureaucracies. Like bureaucracies, partnerships and NHOs are rule-bound. Elected officials have to be procedurally fair in decisions that affect individuals' roles and rewards (or penalties). Members and partners are more likely to regard these rules as legitimate, the more the rules are formalised, equitable and apply what the members regard as relevant, valid criteria when selecting individuals for responsible posts (118). Members have impersonally defined roles which do not depend upon which particular person holds which role (unlike, say, a feudal estate or charismatic sect). The elected representatives have also to maintain unified objectives, culture and ideology for the organisation. Decision-making is at least partly centralised. Where partnerships provide a rather standardised service to a dispersed clientele, a centralisation of technical functions is likely to co-exist with decentralised authority-structures. In partnerships resistance to centralised control (even within the partnership) and the high differentiation of the services provided mean that partnerships are likely to set their members general rather than narrow (highly specific) financial targets with concomitant tolerance of (justified) deviation from those targets (103).

2.4.3 Hybrid structures

A partnership or a NHO can, through the structures described above implement its members' or partners' decisions through the members' or partners' own activity. Alternatively the members or partners can hire employees to do so (95), creating a hybrid structure comprising:

1. A 'polycratic' kernel (123) which establishes the whole organisation's goals, monitors and controls the whole organisation.

2. A hierarchy of employed staff subjoined to the above, a bureaucratic infrastructure essentially similar to those found in public or commercial bureaucracies.

Any differences in behaviour between such hybrid organisations and conventional bureaucracies must therefore stem from the democratic kernel (1). In these hybrid structures there is a parallel between the role of the partner or member and that of the owner of a small owner-managed firm; and a parallel between the roles of the most senior employee in either kind of organisation. Because professions by definition exclude non-professionals from their work, creating sharp demarcations between professionals and non-professionals, hybrid structures are especially likely to appear in partnerships.

Hybrid organisational structures necessarily have an interface between the democratic and the hierarchical components. The subjoined hierarchical element is managed either by the partners collectively, via a generalist manager who then stands a the apex of the hierarchy as the link between hierarchy and partnership, or by a designated partner (an 'executive partner'). This role has parallels with that of a boundary-spanner (138) and involves role-conflict (139), which can be reduced if members and the boundary-spanning top manager have a similar view of the organisation, its task and environment and if a commitment-based rather than a control-based approach to management is applied (140).

Relatively high in these subjoined hierarchies are trainee professionals, potential future partners (118). Greenwood and Empson (33) and Pinnington and Morris (115) argue that 'tournament' career paths are typical of professional partnerships. At a certain point in her career the salaried trainee professional must either obtain promotion to become a partner or lose her post ('up or out'). This is considered a motivator to the would-be partner and enables the partnership to refresh its supply of employed professionals periodically (141). Implicitly, the role of employee is considered unsuitable as a long-term position for a member of the privileged profession to remain in. Consequently Greenwood and Empson hypothesise that:

Partnerships and private corporations that use tournament career practices are more efficient than public corporations in the production of professional services because they offer superior career incentives to professionals, which result in higher effort and productivity. (33)

In part the subjoined hierarchy is managed through similar methods of coordination (evidence-basing; appeal to culture and values; recruitment and expulsion) to the democratic layer (123). Ideologies and culture in particular are likely to work best as means of control if they are consistent across the different parts of a hybrid organisation. One might therefore predict that the organisational culture of hybrid organisations would favour a participative approach to the management of their employees. For technical reasons EBM (or its analogues) would also be unchanged.

What differs is that in the democratic layer, control amongst the members is democratic and bidirectional whilst in the subjoined hierarchy managers exercise unilateral control (rewards and punishments) over the employees (133) on behalf of the members. The methods are essentially those applied in bureaucracies elsewhere: hiring, firing, pay differentials, promotion, demotion or redeployment at managers' decision, or - more subtly - 'responsibilisation' i.e. making employees at the bottom of the hierarchy responsible, besides the managers, for devising and implementing solutions to the increase the organisation's capacity to meet its objectives through such methods as TQM and problem-solving (142).

2.4.4 Professional engagement

In current NHS discourse 'professional engagement' is usually an ellipsis for 'willing participation in the management of the NHS and in implementing national policy'. 'Professional' covers all NHS clinical occupations, but above all the medicine as the most privileged, powerful and independent. Active professional participation in NHS managerial activity would obviously be evidence of engagement. So, paradoxically, would critical 'voice' within these bodies (143). Professional members' 'exit' from managerial bodies would be evidence of disengagement, as would active or passive resistance towards NHS managers' decisions or national policy.

In a partnership with a subjoined hierarchy the partners combine the roles of owner, manager and professional (103) with three corresponding income streams:

1. Payment for their own labour.
2. Profits from the employees' work (141), as in a corporation.
3. Monopoly rents resulting from closure of the partners' occupation (its status of a profession).

All these activities are managed or undertaken by the partners. Artificial measures to promote professional engagement, at least by the partners, therefore appear somewhat redundant in such a structure. More likely the opposite question arises of how to engage non-partners', including employed professionals', engagement in the partnership's decisions and activities.

For professionals employed by partners and for professionals in non-hierarchical structures the question of how to promote professional engagement is more meaningful. Above we predicted that when individuals controlling their conditions of work will seek to do what they regard high-status activity under good working conditions for a sufficient livelihood, to undertake learning and self-development, and realise the other non-economic values which are important to them. It seems reasonable to predict that the more a structure satisfies those goals, the greater professional engagement with its management is likely to be. Hence

partnerships and provider NHOs will establish the following modes of professional engagement, which Table 1 also compares with the structure of a public hierarchy, such as an NHS Foundation Trust.

Table 1 suggests that professional engagement would be strongest in professional partnerships, less so in NHOs, and less again in a 'public firm'. All four organisational structures mentioned in Table 1 let clinicians work according to professional ethos and discipline, albeit as defined and constrained by national policy (144,145). The presence of professionals, especially doctors, in NHS (and other health systems') managerial bodies arises from a political settlement rather than any intrinsic structural characteristic of hierarchies. Job satisfaction can be assumed to be associated with professional commitment to the organisation for which the professional works, and commitment to be associated with engagement. Professionals are also likely to be more engaged when they have specialised skills which complement those of other members of the same organisation (118). How far that occurs depends however upon the technical characteristics of health care processes and the micro-politics of team-work (146) rather than upon organisational structure.

Table 1. Organisational structure and professional engagement

	Professional partnership	Provider NHO	Consumer NHO	Public (hierarchy)
Professional representation on Board*	Yes	Yes	Yes	Yes
Professionals control Board	Yes	No	No	No
Professionals jointly own organisation's assets	Yes	Partly**	No	No
Professionals allocate organisational income	Yes	Partly	No	No
Professionals profit from non-professionals' work	Yes	No	No	No
Professionals define own terms and conditions of work	Yes	Yes	No	No

**'Board' means 'top-level controlling body' (even if not actually called the 'Board').*

***'Partly' means that the professional members participate as equal voting members with others.*

2.4.5 'Degeneration'

A fundamental question in a hybrid organisational structure is whether the two organisational structures making it up are compatible and can coexist or whether one will eventually predominate, leaving an unmixed structure of one kind or the other (147). If a corporate structure prevails, the original structure is said to have 'degenerated', a decidedly normative expression connoting backsliding form egalitarian and democratic principles.

Partnerships are, we noted, especially liable to adopt a hybrid structure. Adopting corporate managerial practices may therefore be more acceptable to them than to a cooperative or mutual. Cooper et al. ((71) describe how a 'P^2' archetype (traditional partnership) becomes overlaid with a managed professional business (MPB) archetype with more corporation-like goals and ideologies which value profitability, marketing and competitive success, productivity and client service above (as in P^2) democratic control and

expert knowledge. Standards of work become more bureaucratised. There is a greater specialisation and greater reliance on rules and cross-functional teams as integrative structures. The relationship between individual goals and those of the 'organisation' (i.e. the group who control it) becomes subtly reversed. Managerial control among partners replaces a more collegial, democratic relationship. Notwithstanding some counter-argument (148), Ackroyd and Muzio conceptualise these changes as a less fundamental shift towards a 'reconstructed professional firm' (149,150). In medicine, McKinlay and Arches ((151) describe this shift as presaging the 'proletarianization of physicians'.

It has been argued that non-hierarchical organisational structures are impractical or unsustainable because they are liable to the following kinds of 'degeneration'.

1. The 'iron law of oligarchy' (57). Where peer control depends on social capital, power is likely to be unevenly distributed among the members of an organisation (103), and to become more so because successful use of informal sanctions strengthens the social capital of those members who already had enough of it to be influential in the first place (67) If the organisation is financially successful, the members who own a most of the equity of a partnership (86), are better educated (152) or have better external networks with the ruling party (122) or financiers take control and establish themselves as de facto owners of the enterprise.

2. Employing wage-labour rather than recruiting new members or partners. The subjoined hierarchy eventually dominates the whole organisation, diluting its democratic character, leading to demutualisation (153,154) and re-instating the divergence of interests between employer (members or partners) and employees found in corporations (155,156).

3. Selling equity (shares) to external financiers, or indeed the organisation's own managers (152), dilutes the members' ownership and therefore democratic control in favour of financiers whose main interest it to maximise the cash return on their investment. The organisation's structure and property-rights converge upon those of a corporation. From within, members prefer will prefer converting the organisation's surplus into income for themselves to re-investing it in the firm.

4. Generational attrition. As the organisation ages its younger members are more weakly ideologically committed than the founders and tolerate reversion to a more conventional organisational structure (117).

5. Weak decision-making. Democratic decision making is alleged to be too slow for responses to changed market conditions, (government policies or other environmental contingencies. Because members support

diverse values rather than the single goal of maximising profits, decision-making in NHOs will be more conflict-prone than in corporations, hence slower and with higher transaction costs (157) because a majority, or even consensus, has to be achieved (115). Decisions on controversial questions are likely to be fudged rather than consistent or clear-cut (155). Members will de-select leaders who try to manage them in ways they dislike (158). That 'unity of command' which Fayol (159) regarded as an advantage of hierarchy will be absent and corporations will out-compete the NHO.

6. Insufficient access to capital. Insofar as external financiers believe point (5) applies, NHOs will find it hard to raise capital. An NHO which cannot sell its equity offers poor security against loans and is less willing to pay interest or rents than a corporation is (160). For partnerships in an English-style legal system, the larger the risks of litigation become, the more the partners will wish to isolate their personal wealth from those risks and the more inadequate their personal wealth becomes as security for the loan required should the partnership be sued. So 'As the degree of capital intensity increases, the professional partnership will be replaced by the private or public corporation' (33).

7. Free riding. Each member has an incentive to shirk and not (vote for strong work monitoring mechanisms because his share in the total profits is small (161,162). Equal distribution of nett income rewards members of less than average productivity at the expense of those of greater than average productivity. Thus the former are likely to join the cooperative and the latter to leave (163). Checkland (9) predicts that if general practice partners recruit salaried doctors as employees the latter will stick to their defined workload and avoid taking on more.

8. Consumer irrationality creates a tension between market demands and the organisation's goal of maintaining what its members regard as high product quality. If market forces make the partnership or NHO indulge what the members might see as consumers' perverse, ill-informed demands (perhaps stimulated by corporate marketing), the result is 'mission drift' from the original goals (164).

9. Becoming bigger. The larger an partnership's or NHO's financial base the more readily it can employ staff (106,165) whilst larger size makes collegial management harder (33). Before the recent financial crises one argument for privatising cooperatives and mutuals was these NHOs were too large for worthwhile member participation (166). The influence which one person can have and their share of the collective benefits diminish. Then controls on poor managerial performance weaken (89). The larger the organisation, the harder for it to avoid the free-rider problem (69).

10. Becoming smaller. Vanek (167) proposed what others have called 'the self-extinction theorem' ((96), p.769). The fewer members a NHO has,

the larger the amount of distributed surplus each receives, so these organisations will tend to under-recruit members. But then in order to restore an optimal capital-labour ratio they will have to reduce the amount of capital they use; which makes it possible to reduce membership further; and so on until the organisation dissolves itself.

11. Diversification. Heterogeneity of services provided and therefore of the professions involved removes uniformity of professional ethics, making collegial management harder; and commodified production is anyway more suited to bureaucratic modes of organisation (33).
12. Equity release is impossible. When members leave the cooperative (as eventually they all must) they will not receive the value of the cash flow generated by assets which they helped create. Therefore cooperatives will under-invest in assets whose life is longer than members' career there (168), (hence invest less in such innovations than a corporation would. Consequently cooperatives are likely to be under-capitalised (155). Against this, a career is a longer planning horizon than most capital markets consider (169).
13. Equity release is possible (the 'exploitation hypothesis'). The opposite prediction (170) concerns cooperatives with a large accumulated surplus, a high proportion of long-standing members (who stand to gain more than younger members do from acquiring some of the cooperative's present equity), growth in profits (hence undistributed surplus), little competitive advantage, and a rising proportion of newer members. Then, longer-standing members, and perhaps the managers they employ, have the opportunity for windfall gains by selling of the cooperative's equity to its founder members (100). However one-member one-vote governance provides a limited protection against this event (154).

2.5 Process

In health care as elsewhere more than one 'technology' (core process) is sometimes capable of producing a given good or service. This raises the questions of whether the specific type of organisational structures found in partnerships and NHOs, tend to:

1. Select certain types of core process (technology) rather than others.
2. Operate a given type of core process in specific ways characteristic of NHOs.

A core process includes not only the production of a good or service but also its distribution to users. Distribution and marketing are therefore also involved in the core process. Indeed many cooperatives have originated asdistribution and marketing organisations.In this context, 'process' means not the organisational activities ('organisational processes') which occur within such a structure, but the core productive process – the 'technology' –

by which an organisation actually produces the healthcare or other goods and services, and thereby also the policy outcomes of interest to policy-makers and managers.

2.5.1 Production of goods and services

For organisations in a market or a quasi-market, obtaining a specified income for members implies, sustaining a level of sales and therefore output sufficient to generate a break-even income. Assuming that producer organisations face declining average total costs over their range of production possibilities (171), that implies creating and exploiting economies of scale and scope up to that point. Even voluntary organisations which do not aim to generate livelihoods for their members nevertheless have to obtain sufficient (if proportionately smaller) inputs to sustain their core process (cover operating costs). When NHOs rely on donations or other fixed or precarious sources of income or inputs, they face the necessity of maximising the output from a given set of inputs. That is, they try to maximise efficiency in the sense of minimising the inputs required to produce a unit of output, and therefore select core processes accordingly.

To obtain livelihood for members of a given occupation implies selecting processes of production which guarantee a role, or a fortiori give the central role, to the occupation in question. For to select a process of production is also to select (a limited range of options for) a division of labour. In this respect, members are likely to be risk-averse and reluctant to diversify their activities very far, leading to relatively conservative investment decisions (172,173). Maintenance of what the members regarded as good working conditions is likely to promote the adoption of working processes that automate or remove laborious, hazardous or low-status (see below) elements of the work process. The goal of creating working activity and its products which their members regarded as being of good technical quality and befitting their occupation is a second reason to predict that NHOs would (in contrast to corporate and many public bureaucracies) resist working processes that routinised or de-skilled work. If anything they would adopt work processes that increased the skills required for existing occupational groups, transferring their own less skilled work a (putatively) less-skilled occupation, providing the latter with tasks at the top of their range of skills. Thus the division of labour would, so to speak, shift 'upwards' in terms of skill for both occupations. Such changes would also satisfy the goal of promoting learning and other forms of self-development. In partnerships the additional profits from this 'leverage' (extended work roles) of employed staff accrue to the partners. This tactic implies codification of knowledge so that it can be transmitted to employees who are less expert than the partners (141).

Quality of product would, we predicted, be defined on a priori technical and normative grounds. This obviously implies the selection of processes of production intended to to produce a complete, integrated product or service

realising those standards. Conversely such a goal also implies not producing what the members or partners would regard as technically redundant or superfluous products or services, including ones over-specified for the consumer need they were attempting to satisfy. If the partnership's or NHO's product or service quality is defined on technical or normative grounds, that implies also a policy of transparency ('honesty') about its specification in informational, promotional or marketing materials.

It is difficult to predict a priori what effects upon selection and operation of the core process of product would arise from the non-economic values that members held. For those effects would depend on the content of those values, hence upon the social origins (112) of the NHO itself. However paths for NHO formation include 'rescuing' an earlier enterprise or the pursuit of other localised goals. Then the NHO would limit the scale of its core process to its community or place of origin.

2.5.2 Consumer NHOs

Consumer NHOs operate either or both of the following core processes:

1. Mediating in interactions between its members and third-party providers so as to shift the balance of information and bargaining power in the members' favour when buying complex services such as healthcare (25). Ancillary to such interventions are social marketing campaigns (e.g. to reduce the fat, sugar and salt content of foods) aimed either at the producers of consumer goods or at changing state regulation of the producers.
2. Commissioning services on its members behalf. This requires well-developed search, bidding, legal (contractual), financial control and monitoring processes. It also requires negotiating and bargaining skills and, in a large organisation, consumer research staff to elicit and formulate its members' demands as consumers, and to recruit new members (subscribers). It may involve 'conflict handling' or discrepant demands from different groups of members). Typically these activities require a subjoined hierarchy of specialised staff.

To resource the above requires recruiting paying members, and any consumer NHO needs activists to run it.. To this end Birchall and Simmons (174) propose a four stage strategy of identifying 'mobilisation potential' (reactivating membership lists, conducting member research), making membership more meaningful (providing better information to members, re-establishing democratic processes), building confidence and trust, and making organisational structures focus on their accountability to members.

2.5.3 Marketing mix

One way to summarise the above predictions is to contrast the marketing mix (175) which the above accounts imply a partnership or NHO will

develop with its corporate counterpart. The two marketing mixes will have some features in common. The legal framework usually sets minimum requirements for the content and veracity of consumer information, product quality and safety. The same regulatory and ethical codes apply to professionals whether they work in a partnership or for an employer.

Table 2 predicts the differences which, because of their different goals, will nevertheless remain between the marketing mix of a producer NHO and that of a corporation. The table sets out the two types of organisations' preferred marketing mix, given their goals. Actually achieving this mix in practice may of course prove to be another matter.

Table 2. Marketing mix in NHOs and corporations

	NHO	Corporation
Product	Pre-defined quality standards. Products guarantee members' centrality to production.	Product differentiation, unique selling points. Products designed to maximise sales volume and saleable 'value added'.
Price	Break-even.	Initially below-cost price if necessary to gain market entry or remove competitors; thereafter highest sustainable price.
Promotions	Transparent, technical content and/or representation of NHO's non-economic goals.	Persuasive sales promotions
Place	Often tied to place (in the geographical not the marketing sense), local identity.	Footloose: any profitable sales channel or geographical location.

The goals of guaranteeing members' livelihoods and a predefined quality of service implies break-even pricing. The goal of predefined quality standards implies implies transparent and rational sale promotion methods; but as noted this may come into tension with the imperative to obtain income. A profit-maximising goal implies maximising the saleable 'value added' to products even when, in the terms NHO partners or members would accept, the added value is technically superfluous (e.g. surgery for cosmetic not therapeutic reasons). In the long term a corporation also has to obtain a break-even price for its goods (indeed more), but what costs that price covers and their relative size is likely to vary between the two kinds of organisation. For instance NHOs have no costs of payments to shareholders to bear, but are likely to have higher wage costs resulting from reluctance to de-skill, casualise or dismiss labour.

2.5.4 Impact on clinical workloads, job satisfaction and morale

Professional engagement itself constitutes one piece of evidence for professional satisfaction with their working life, hence morale. Accordingly one would predict (from Table 1) professional morale and work satisfaction to be highest in professional partnership, and successively lower in provider NHO, consumer NHO and NHS foundation trust (or similar hierarchy).

Professionals who control their own working conditions might be predicted to shift the profile of their workload towards the kinds of work attractive to

clinical professionals: work which their training equips them for; work whose difficulty attracts prestige or status in the profession (176); or simply work which interests or psychologically rewards the individuals involved. If so, less-esteemed types of work would either be transferred to other occupational groups or (if they refused it) be dropped. One would also predict a clinical workload that selected either highly-paid activities and/or activities that enhanced the equity value of the partnership itself. Greenwood and Empson (33) hypothesise that because partnerships use tournament career practices, they offer superior career incentives to professionals resulting in higher effort and productivity i.e. workloads. Given NHOs' goals, one would predict higher pay for equivalent work than in public or commercial bureaucracies. However one effect of restricting entry to professions is to create shortages of that kind of labour. Then competitive pressure to recruit scarce professionals would compel other organisations to offer salaries similar to a partner's income. Because of their relatively egalitarian origins, one would predict lower pay differentials in NHOs and partnerships than bureaucracies.

2.5.5 Development of innovative practice

Greenhalgh et al. (177) find that an innovation is more likely to be adopted when it is:

1. Capable of small-scale trial
2. Reversible
3. Compatible with existing working practices
4. Compatible with existing organisation members' 'values'
5. Compatible with existing ways of measuring 'success'

Conditions (1) and (2) are technical characteristics of the innovation which apply irrespective of organisational structure. However because partnerships tend to be small organisations, a sufficiently 'small' scale on is likely to be smaller than elsewhere. 'Compatability' requirements (3), (4) and (5) imply that innovations are most likely to be adopted when they conserve the existing patterns of control and benefit-distribution in an organisation. In health care, the necessary 'receptive' organisational context (178) includes absence of professional opposition (179,180) and, in partnerships and NHOs no opposition from the members or partners (rather than employees). Assuming that an NHO or partnership adopts innovations which reflect its organisational goals (181), Table 3 outlines what preceding sections imply will be the pattern of innovation in professional partnerships and NHOs.

Table 3. Predicted patterns of NHO and partnership innovation

	Provider NHO	Partnership	Consumer NHO
Dominant interest	Working members	Professional Partners	Activist consumers
Aims of adopting innovation	Safeguard or increase income Improve working conditions Raise (member-defined) quality of product	Raise (partner-defined) quality of product Conform to professional norms and discipline Increase partners' profits	Raise service specification, remedy defects Reduce costs to (consumers
Technical character	Labour saving. Saving non-labour costs.	High skill, high status work. Undertaken or controlled by partners' (profession(s)	Inspire new providers Marketing (to recruit subscribers; social marketing) Discursive (new forms of contract etc.)
External sources of innovation	Other providers in sector Commissioner demands (in quasi-market)	Professional bodies Small owner-managed business (for organisational innovations) Commissioner demands (in quasi-market)	Interest and pressure groups

For producer NHOs, the objective of maintaining members' incomes and working conditions implies preference only for cost-reducing innovations which do not intensify or routinise work but do save costs in other ways (e.g. fewer inputs, less processing). Labour-saving innovations (e.g. mechanisation) are compatible with this goal but not innovations which reduce costs by reducing wages. Mechanisation would imply a shift towards 'commodified' (i.e. mass) production. As explained, some micro-economists predict that NHOs will make fewer long-lasting, capital intense innovations

than corporations do. Because it does not distribute profits, a producer NHO has less incentive than a corporation to profit from quality-reducing innovations (182).

Partnerships would select similar innovations but with the additional constraints of selecting only innovations which retained the partners' control over the core processes (even if the partners no longer do the work personally), not innovations which introduced technologies which the partners could neither operate not control, and no innovations which risked causing large debts, for which partners have unlimited liability. That is a more conservative pattern of innovation than in limited liability or non-hierarchical producer organisations.

Not being controlled by producers, consumer NHOs would be open to a wider range of productin innovations than partnerships or producer NHOs, including innovations that radically altered the division of professional labour or even de-professionalised care provision.

2.6 Outcomes

The above framework yields implications how far the distinctive organisational structures described would tend to produce the NHS policy outcomes of interest to the present project. Those of professional engagement, of impacts on clinical workloads, job satisfaction and morale, and of innovative practices are discussed above. There remain four others.

2.6.1 Impact on clinical quality and development of best practice

Here we equate clinical quality and best practice with the uptake of evidence-based practice, in contrast to studies (101) which implicitly equate clinical quality with intensity of diagnostic testing and treatment (and equate these with doctors' 'effort').

Left to themselves, one would predict that partnerships and NHOs would develop a collegial, relational model of clinical governance in contrast to more 'Fordist' (prescriptive, documented, formalised, standardised) approaches to clinical governance (144). Nonetheless the mechanism of mutual scrutiny 'a mechanism more readily operated and potent within an organisation than an inter-organisational network 'would tend to homogenise clinical practice. The goal of allowing NHO members to concentrate on what they regard as work befitting their occupation and as high-status work implies that one would expect to see evidence-basing focussed and the development of clinical practice being at the level of the interaction between the individual clinician and patients, and on the more medicalised areas of care (183).

Because they do not directly produce health services, consumer NHOs implement evidence-based clinical guidance only indirectly, by proxy through service contracts (or the equivalent). On would therefore expect

them to adopt more epidemiologically- than clinically-oriented approaches to evidence-basing, leaving the clinically-oriented approaches to providers (including partnerships and producer NHOs). To define quality of care standards in whatever services they commissioned, they would have to rely upon prior definitions in service contracts and upon post-facto monitoring of providers' quality of care. These techniques for external implementation, hence the corresponding patterns of innovation in them, are the same as for corporate and public commissioners. But insofar as consumer NHOs originate as responses to market or state failure, they would innovate by commissioning types of services not commissioned by other commissioners i.e. unprofitable services, controversial services, services with low status among the clinical professions and services for 'undeserving' care groups. In short, their innovations would occur on the (current) margins of the health system.

2.6.2 Adherence to external performance targets

For present purposes we take the external targets in question as being those set by service commissioners, government departments, regulatory bodies and international organisations.

The extent to which these external bodies can exercise governance over another organisation depends, firstly, upon how the objectives of the NHO or partnership membership align with the external performance targets. If they do align, the external body's capacity to achieve adherence will depend on the character of the accountability chains (184) (number of intermediate organisations, character of the links between them, consistency of the targets involved) linking them to (in this case) the NHO or partnerships. In a quasi-market professional partnerships are embedded in triple accountability chains: to commissioners, to regulators and to professional organisations. External targets which all three chains endorse are therefore likely to be highly salient to a professional partnership, hence likely to be implemented.

Many NHOs form however in response to apparent failures of the public sector, or a fortiori in opposition to public policy. Then this alignment of objectives is unlikely. Their adherence to external performance targets will be achieved only the the extent that the commissioners (and other target-setters) exercise power over them. We adapt Therborn's account (185) of power for to explain how susceptible partnerships and NHOs are to external sources of power.

Obviously external bodies cannot select (or rather, elect) the topmost officials or managers in NHOs or partnerships nor manage any conflicts within them, but simply because these organisations are independent not because of their internal (organisational structure. These organisations' adherence to external performance targets will therefore depend on the following remaining conditions.

1. Law and regulation. Whilst the legal and regulatory framework for professions covers (also) professionals in partnerships and NHOs, it is usually too broadly defined to enforce adherence to specific policy or managerial targets. Typically, contracts are the main legal or regulatory mechanism for producing adherence to external targets. Their effect depends upon how the contracts themselves were formulated, what incentives attached to them, and whether the partnership or NHO was willing to sign such a contract in the first place.

2. Resource dependence and bargaining power determine the willingness of partnerships or NHOs to do so. Cornforth and Simpson (186) suggest that smaller organisations (which partnerships often are) are more dependent on external resources and than larger ones (such as NHS trusts). However it may be that what matters is not the size but the proportion of an organisation's resources coming from a given external source, in this case NHS commissioners. In that case, professional partnerships in England would be highly adherent to external targets because few of them earn enough income from non-NHS sources (medical certification etc.) to meet their income requirements. Probably fewer than 2% of English general practices, largely in London, are sustained mainly by private income. NHS commissioners' near-monopsony power is thus their main means of achieving partnership and NHO adherence to policy targets.

3. Impersonal power. When one occupational group alone can operate a technology for which there is no substitute, for example by maintaining an occupational closure, it gains power thereby. including the power to resist or temper external targets. However, because such power accrues to an occupational group because of its technical role in a core productive process, it is the same across all organisational structures.

4. Ideological persuasion. The likelihood of adherence to an external target will obviously be increased if the commissioner can persuade the NHO or partnership of the legitimacy of that target in terms the members' or partners' beliefs and the types of NHO or partnership goals listed above (. If the external targets align with these beliefs and goals, the NHO or partnership would adhere to the targets more willingly than (say) a corporation, whose goals are independent of such considerations. But the content of the organisation's ideology (could equally stimulate resistance to external targets, starting by recalling any elected managers who (members or partners thought) were pursuing external targets against the members' interests or beliefs.

5. Transparency (187). The ability of a commissioner or other external body to secure adherence to its targets depends also upon whether it can detect adherence or non-adherence to them; that is upon whether the organisations' activity is transparent to the commissioner. Because they tend to pursue a different competitive strategy than corporations

do, and tend to make their internal managerial regime and working processes transparent (in contrast to 'commercial confidentiality'), it would be easier for commissioners to verify adherence (or not) to external targets on the part of partnerships and NHOs than on the part of corporations.

2.6.3 Patient experiences

Patient outcomes and experiences have two main components. Within the limits of existing health care technologies the outcome of clinical care depends upon the extent to which it is evidence based (see above). That leaves the matter of how far services conform to patients' expressed desires or preferences in such matters as convenience and how 'user-friendly' services are (e.g. relationships between staff and patients). In partnerships and NHOs (as other organisations) that depends upon what mechanisms exist for patients' expressed needs to influence decision-making.

Professions (hence professional partnerships) subscribe to codes of ethical conduct in dealing with patients but these codes focus upon honesty, informed consent etc. rather than specify such matters as the convenience, range or user-friendliness. The goal of what members of partners define as high-quality care is, in health care, likely to include its clinical effectiveness, an outcome which patients also want. But given their origins, the goals of professional partnerships and NHOs will not necessarily include a goal of user satisfaction of their experience of health care. Neither can it be stated a priori how the goals of maintaining members' livelihoods and working conditions will impact upon the quality of service as clients experience it. (For producer NHOs, user participation in decision making is perforce marginal. Their democratic structures exist to give effect to the collective will of the members not consumers. Provider NHOs which rely upon user participation in decision-making and management are therefore likely to have an extent and effect as limited as has been reported (188,189) for some public bodies. Since partnership and NHO goals express partner nor member (i.e. producer) rather than consumer interests, a coincidence between these goals and consumers' expressed wishes is more likely to be the exception than the rule.

If they do not spontaneously align, that alignment has to be created artificially from outside, either by a commissioner (whether an NHS commissioner or a consumer NHO) or by the consumers themselves. In a quasi-market, patient outcomes then depend upon the extent to which the commissioners are willing and able to convert users' preferences for services into contractual requirements, and then ensure adherence to those requirements. The conditions under which a commission would have the power to do so are outlined above.

Consumer NHOs are the polar instance of user participation 'or rather control 'as the mechanism whereby consumers' preferences determine the

goals and activity of an organisation. For these organisations, the extent to which they achieve the outcomes that their users want depends on:

1. How faithfully they implement the members' decisions; that is, upon the extent to which they have not 'degenerated' (see above). Where alternative cooperatives exist, members may try to influence consumer cooperatives' behaviour through 'exit' rather than 'voice' (143).
2. The extent of their market power over providers, also described above.
3. Their capacity to produce for themselves the services their members require, i.e. become a combined producer-and-consumer NHO.

Consumer NHOs have the specific goal of obtaining services which would not otherwise exist for their members, and achieving that goal would the organisations' distinctive outcome for consumers. The same applies to the ancillary goal of making accurate information about products and services available to its members.

2.6.4 Cost-effectiveness of service provision

The effectiveness of service provision, i.e. the extent to which it is evidence-based, is considered above. Whilst a corporation has incentives to minimise the cost of its goods or service so that the residual shareholder profit is maximised, it does so in order to pass the savings on (so far as possible) to shareholders not payers. A partnership or NHOs has the financial goal of breaking even (in the sense defined above), hence of containing (rather than minimising) costs so that its income covers them over time across all its activities. On the assumption that cost changes are reflected in prices to the payer, the foregoing material suggests three conflicting predictions for the impact which producer NHOs and partnership have on the costs of service provision to those who pay for the services.

1. Increased prices, because one goal of producer NHOs and professional providers is to maintain its members' income and working conditions at more generous levels than the prevailing market rates (106). The goal of producing high-quality goods or services (as defined by members or partners) may also be presumed to increase costs.
2. Decreased prices, because shareholder and rentier payments are avoided. Members or partners pool risks and cover fluctuations in each other's overloads, which if anything reduces the unit costs of services. Many NHOs also rely - sometimes heavily - on voluntary labour including that of informal carers (which some commentators (190) regard as cost-shifting). It has also been argued that a well-motivated, more contented, self-managed workforce will be more productive than an hierarchically managed one (191,192). Cooperatives entering an oligopolistic market may produce 'yardstick competition', raising output and reducing prices compared with an oligopoly (193), and with a corporate monopoly (194). Also:

Because professional partnerships have higher reputations than public corporations, they enjoy lower status-based costs and are thus more efficient in the delivery of professional services.

(33)

3. Unchanged prices, because the prices of services are determined by the balance of demand and supply across the sector as a whole, not by the internal structure of the producer organisations, so long as these organisations are 'price takers' rather than 'price makers'.

More generally, it has been argued that NHOs are likely to be inefficient, have high transaction costs (195) or 'distort' market incentives. Kremer (196) argues that worker cooperatives' habit of redistributing income among members distorts (market) incentives. If the median member has less than average ability, the cooperative will vote for income redistribution, weakening personal incentives; but members who lose by this (i.e. contribute more than the average) will be reluctant to leave since this entails forfeiting the dividends on their capital contribution. This argument assumes that members make a personal cash payment to join the co-operative but cannot then sell or otherwise recoup it. When there are no share prices to reflect managerial efficiency, the incentive to monitor that efficiency is reduced ((155) and cp. (117)). A hybrid structure as described above insulates the employees from the effects of external variations in incentive or other payments (69). Against this, members of a partnership or NHO which distributed its profits equally would (paradoxically) be more directly exposed to market or quasi-market incentives than, say, the employees of a corporation who receive fixed salaries with only the owners being directly exposed to market incentives. In sum, markets will select against inefficient non-hierarchical producers, which implies that market survival is evidence for, and extinction evidence against, their micro-economic efficiency. Many predictions of degeneration or conversion cite inferior microeconomic efficiency either as reasons why NHOs (especially) will in fact be rare (147), or as reasons why economic policy should make them rare.

Such predictions have an empirical but also a normative content. The latter is usually the neo-classical micro-economic assumption that Pareto-optimal competitive equilibria are the normatively desirable outcome of economic activity. Some writers (e.g. (197)) expressly argue that if a non-hierarchical organisation exhibits different patterns of price, output and factor use to a perfectly competitive corporation, then since the latter is a priori efficient, non-hierarchical organisation is not. Supporters of non-hierarchical producers might reply that to 'distort' or neutralise certain market incentives is a merit, not a defect, of these organisations.

Consumer NHOs aim to increase consumers' bargaining power vis-a-vis providers which ceteris paribus would reduce prices and bring quality specifications close to users' preferences as articulated by the NHO. Compared with individual consumers, consumer NHOs will achieve lower

prices than the hitherto prevailing market price ((106) for a given service specification (range or quality or both); or higher service specification for a given price. For a consumer NHO is in a stronger bargaining position than individual consumers to negotiate these benefits. For the same reasons the consumer NHO would achieve wider eligibility of access.

3 Research aims and questions

3.1 Research aims

In light of this background, this project aims to contribute to improving the evidence base about, and so an improved understanding of, how professional partnerships and NHOs as organisational structures produce (or not) distinctive effects on the cost, quality, effectiveness and user experience of the services they produce. Among the rationales for such research are the need for an evidence base for decisions about what kinds of partnerships and NHOs the NHS should incorporate or commission. There is also a simple scientific rationale. Despite the prevalence of partnerships and HHOs existing body of organisational research into these organisational structures is evidently deficient.

3.2 Research questions

We adopted the research questions stipulated in the research brief but altered their sequence to match the environment-structure-process-outcome ('ESPO') framework described above.

1. Organisational Environment:
    a. What are the goals (explicit and implicit) of such organisations and why/how are they established?
    b. What is the nature of the governance and incentive arrangements that are placed on these organisations from external bodies? Is there an effective form of regulation, and if so what is th e nature of this?
2. Organisational Structures:
    a. What are the structures and internal organisational arrangements of non-hierarchical organisations and partnerships? How are professional partnerships and non-hierarchical organisations co-ordinated, and what makes for a successful co-ordination strategy?
    b. What are the key elements to the internal management of such organisations?
    c. How do professionals within such organisations interact with each other and how do they regulate themselves?
    d. How do such forms of organisation impact on securing professional engagement?
3. Process: How do such forms of organisation impact on:
    a. Clinical workloads, job satisfaction and morale?

b. The development of innovative practice?

4. Outcomes: How do such forms of organisation impact on the policy outcomes of:

   a. Clinical quality and development of best practice?

   b. Adherence to external performance targets?

   c. The cost-effectiveness of service provision?

   d. Patient outcomes/experiences?

This report does not consider informal organisations within bureaucracies (e.g. trades unions), organisations which exist solely to promote political causes or vested interests, or 'partnerships' as the term is used in normative accounts of the professional-client relationships (e.g. (198)). Neither does it consider inter-organisational networks, collaborations or contracts, or network-based sharing schemes (199). By non-hierarchical organisations we mean organisations controlled by their members on a one-person-one-vote basis. This definition excludes employee shareholder schemes (wherein employees are a minority shareholders and voting is per share not per person) (117); worker 'participation' in management (as opposed to control) including 'co-determination'; and consumer participation in (as opposed to control of) public bodies (e.g. Sure Start schemes (200)).

As research questions 2(b) does, (and some researchers (201) also, we reserve the term 'management' for governance by bureaucracy (hence, hierarchically) and the term 'coordination' for the egalitarian and democratic governance which, in different ways, both NHOs and partnerships use. We therefore take RQ 2(b) as (referring both to democratic governance, and (to the line-management element in hybrid structures. Throughout this report we (use 'member' and 'partner' to denote the people in NHOs and partnerships (respectively) who can vote and hold elective office. 'Employees' are the salaried staff who cannot. We use 'worker' to denote (in producer organisations) both categories combined.

As the 'external bodies' mentioned in RQ1 (we focus on the public authorities (PCTs, SHAs, practice-based commissioners) which commission partnerships or NHOs to provide care. We define impact on clinical quality and development of best practice (RQ4(a)) as the extent of adoption of evidence based practice. In 'user outcomes / experience' (RQ4(d)) we include 'service outcomes'(access to services, range of services offered) and the degree of opportunity for users to influence decision-making. We take 'cost-effectiveness' (RQ4c) as a marker for the wider normative criterion of economic efficiency.

Some research questions overlap. Adherence to external performance targets (RQ4(b)) we regard as a special case of external governance (RQ1(b)). To prevent repetition we subsume it under that heading when presenting the findings. Similarly, adoption of evidence-basing (as we now

interpret RQ4(a)) is a special case of the adoption of innovations generally (RQ3(b)) (202). We interpret 'patient outcomes' (RQ4(d)) to include 'service outcomes' (access to services, range of services offered), but the range and scale of services offered depends on what innovations organisations adopt, already covered under RQ3(b). RQ4(b) on adherence to external performance largely duplicates RQ1(b). 'How do such forms impact?' we take to connote: 'What effects are produced and through what mechanisms?' Implicitly RQ2(d), RQ3(a) and the whole of RQ4 invoke a counterfactual: how would the impacts differ from those produced by another organisational structure? The two obvious counterfactuals are 'public firms' (e.g. NHS Foundation Trusts) and shareholder-owned for-profit businesses, for short labelled 'corporations' throughout this report.

4 Methods

4.1 Study design

A multi-method design combined a cross-sectional comparison of multiple case studies with a systematic review. Because comparatively little is known about partnerships and NHOs we adopted dual method. One component was a wide-ranging systematic research review. From theoretical material in found in the review we formulated the middle-range theoretical framework outlined above (ch.2). The other component was a cross-sectional maximum-variety set of exploratory case studies. From them we selected the subset of healthcare sites and made more detailed longitudinal case studies of them. Qualitative testing (203) of the theoretical framework was then possible against two sets of data:

1. Data from the case studies, in particular the more detailed health sector cases.
2. Empirical findings reported in the studies which were systematically reviewed.

The theoretical framework was therefore open to falsification and modification in light of the evidence and findings emerging from the study. Since this was a framework partly of the authors' own assembling the more rigorous approach was to test it in both a falsificationist (204) and a verificationist (205) way. (Although different the two methodologies are compatible.) In testing the framework we deliberately checked for disconfirming evidence.

4.2 Systematic review of literature

4.2.1 Search

The aim of the search was to extend an existing database of the predominantly qualitative research literature on organisational structure conducted for an earlier study (36) to ensure that it covered as completely as possible the relatively sparse and scattered studies of NHOs and partnerships. The systematic review was necessarily an iterative process involving a combination of database searching, scanning existing bibliographies, citation searching and scanning web sites. We electronically searched two groups of databases: a group of cross sector databases on organisational studies comprising ABI-Inform, Scopus and Web of Knowledge; and then a group of health related research comprising Medline, Pubmed and Cinahl. Two separate searches were conducted because the software and user interfaces for the health databases allowed

more sophisticated search strategies (more complex combinations of search terms, hence more specific selection) than ABI-Inform.

ABI-Inform search. The electronic all-sector search used ABI-Inform as the main database, which despite the limitations in its search capacities covers a wide range of economic sectors and organisational types. This search began with scoping searches, using a number of methods, aimed at identifying keywords, journals, authors and organisations for further systematic searching by means of:

1. Citation searches of papers cited in the research proposal
2. Looking up bibliographic records of papers cited in the research proposal.
3. Exploration of subject keywords used to index literature on professional partnerships on ABI-Inform
4. Scanning bibliographies of other commissioned projects within the SDO Studying Health Care Organisations theme and recording relevant papers for potential inclusion
5. Identifying web sites of relevant organisations for systematic scanning
6. The preceding steps led to a search of ABI-Inform, Scopus and Web of Knowledge databases to identify organisational science research on particular types of professional partnership, including management consultancies, law and architecture partnerships.

This search found 1510 items. During these searches we generated a list of synonyms for organisational forms and types of professional partnership in health care which we combined with terms suggested by the research brief and proposal to produce a further search strategy for the main subject search of Medline.

Medline search. We combined the list of synonyms for organisational forms and types generated in the cross-sector literature search with terms used in or implied by the original research proposal to produce a further search strategy for a health-sector search using Medline as the starting main database, and otherwise using the same methods as above. After removing duplicates already found in the preceding search this added 619 items.

The electronic search strategy for Medline is stated in Appendix 2. (The ABI-Inform search used equivalent terms and logic.) The lists of peer reviewed items from the two database searches were combined giving a list of 2129 abstracts of varying completeness and informativeness. The above searches were limited to peer reviewed materials, which we sought in order to find well-theorised, well-evidenced and tested explanations of the relationships between organisational environment, structures, processes and outcomes in NHOs and partnerships. Because of the likely paucity of material, we placed no date limits on the electronic searches.

Hand searches. Besides identifying key journals in this topic area for hand searching, the above steps also showed that because of the disparate and scattered nature of the relevant research, hand-searching would be a more important search method than for topics with a more formalised body of research. More work than first anticipated therefore went into hand searching. We hand-searched a small number of journals which focus explicitly on the topic areas of interest. The hand searches were continued throughout the project period.

As additional sources of data we also wished to obtain unpublished research, 'grey' literature and reportage from non-peer reviewed periodicals. We supplemented the electronic searches with hand searches of websites, beginning with the RCGP and Mutuo, as national bodies of partnerships and NHOs respectively, to collect grey material from them, and to snowball the search on to other sources that they might recommend. We regularly scanned the Health Services Journal, Pulse, the Nursing Times and the social policy sections of the Guardian as the periodicals most likely to contain relevant rapportage. When possible we traced the reported material back to its original sources if the latter were peer-reviewed journal papers. Hand searches of non-peer reviewed grey literature and the media, including the professional press, yielded 112 and 74 documents respectively. Of the latter 16 were in the peer-reviewed part of the professional press (Nursing Standard, Nursing Times etc.).

4.2.2 Selection, coding and data extraction

To select papers for inclusion or exclusion we coded them according to what elements in the ESPO framework their abstracts described and what kind of organisations. Selection of peer reviewed papers for data extraction involved three stages. First, based on the ESPO framework, the research brief and questions we devised the coding framework shown in Appendix 3. To refine the framework the researchers separately coded a maximum-variety selection of 24 papers sampled from the search results. The researchers then met to compare their initial codings. Where the codings differed the researchers agreed more specific coding criteria. This process also helped refine our definitions of what did (or not) count as a non-hierarchical organisation or a professional partnership.

The second stage was to apply these criteria to code all the abstracts. Each abstract in the list of peer-reviewed papers or books was screened by two researchers for relevance to the study. The two researchers selected blind of each other, and items were allocated in such a way as to give each possible combination of pairs of assessors. We checked each possible category of disagreement (i.e. whether paper was about an NHO or not; whether paper was about partnership or not; disagreement over classification of partnership; disagreement over classification of NHO) and what categories of the ESPO framework it was about. Testing of the initial agreement on how to classify the papers by ESPO categories produced a

Cronbach's alpha of 0.42 which is low; alpha > 0.7 is generally regarded as acceptable (206). This level of agreement probably reflected the diversity of the literature being assessed, differences in the researchers' disciplinary backgrounds and the fact that two of the team were new to screening in this subject area. Differences in coding were reconciled by agreeing specific written criteria for categorisation in (previously) ambiguous cases. The criteria were then jointly applied to the disputed categorisations. Items which satisfied the disambiguated selection criteria and those whose abstracts were too brief or ambiguous to indicate whether they were relevant to the present study were then retrieved. Each study was thus categorised according to whether it contained empirical material about partnerships and if so what kind (by economic sector i.e. medical, consultancy, accounting etc.); and whether it contained empirical material about NHOs and if so what kind, again by economic sector. These fields were the first eight of the data extraction instrument in Appendix 3.

Studies which contained empirical findings about at least one ESPO category and at least one category of study organisation were selected for us to obtain the full paper, as were studies whose database entry was too brief or ambiguous to ascertain its relevance from. We excluded papers which were clearly irrelevant, for example because they concerned 'partnership' in the sense of civil partnership or marriage, or what were evidently large bureaucracies. 'Cooperation' or 'cooperative' produced many at best tangentially relevant citations about working relationships between occupational groups. Many papers were found to concern 'partnership' and 'non-hierarchical organisation' in the sense of inter-organisational networks. We donated them to another SDO project on that topic. Nevertheless, so as not to miss materials in a relatively sparse field, we included any papers whose relevance to the present project was uncertain (as opposed to certainly irrelevant). Of 2194 items found in the searches only 330 (approximately 15%) proved to have any relevant empirical findings.

We therefore supplemented them by obtaining:

1. Unpublished peer reviewed research studies from academics and think tanks known to the researchers to be working in this field (cited in the text below).
2. Other relevant papers which appeared in the main journals for the field during the course of the research, and concurrent news rapportage.
3. Apparently relevant papers which we found references to whilst extracting data or conducting other research projects.
4. Hand-searching the last years' issues of journals which specialise in the subject area of this project and which the systematic search had shown to produce relevant papers viz. Annals of Public and Co-operative Economics, Economic and Industrial Democracy, Industrial and Labor Relations Review, the International Journal of Voluntary and Non-Profit Organisation and Labor Studies Journal.

These methods yielded another 191 full text papers, making a total of 521.

The selected items were then downloaded or obtained from libraries or their authors, except for 14 (mostly pre-1980) items which we would could not obtain anywhere. Having obtained the full-text items we excluded editorials, advertorials, non-theoretical data-free papers, empirically irrelevant papers obtained on the strength of an ambiguous, vague or missing abstract, and data-free theoretical papers. These exclusion criteria caused heavy attrition especially among the economics papers (mostly data-free algebraic models), leaving 194 papers with relevant empirical content. Peer-reviewed theoretical but data-free papers were however retained for use in constructing the initial theoretical framework above. Thus the inclusion criteria were that items should be both (1) peer reviewed and (2) have empirical content about partnerships or NHOs or both.

4.2.3 Data synthesis

The pre-selection coding had allowed us to group the selected papers thematically by relationship between ESPO categories i.e. relationship between organisational environment and structure, between organisational structure and process and so on for all six possible combinations. Each researcher undertook to analyse one such theme and all the full text-papers relevant to that theme were allocated to them for data extraction. Data were extracted onto the form in Appendix 3. Reviewers extracted data relevant to not only to their allocated theme but also to all the other themes treated in their allocated papers. For each of the six ESPO themes data from the separate forms were then collated into a single document, which was the raw material for each section of the empirical systematic review findings presented below. This method which immediately exposed any patterns of agreement or of disagreement among empirical findings in the reviewed studies.

Some full-text materials stated theories relevant to the research brief. (Some, particularly economics papers, contained little else.) The foregoing theoretical framework (ch.2) was assembled from these or, where gaps remained, by a priori reasoning. The architecture of the explanatory framework was adapted from an SDO review on organisational form and function (36). In particular, we attempted to deduce from the published studies their implications for public-sector health systems such as the NHS. In this way we generated working assumptions, tailored to our research questions and the research brief, about the relationships between organisational structures and policy outcomes in NHOs and partnerships. We also deduced the taxonomy below (ch.12), following the taxonomic principles described by (e.g.) Pinnington and Morris (74). We checked that the resulting categories were logically consistent, mutually exclusive and together covered all the varieties of NHO and partnership we had found evidence of.

4.3 Case studies

4.3.1 Sampling

Our sampling strategy was theoretically driven. One way to test our assumptions (see above) that organisations' environments determine their founding membership and gaols, hence core processes and organisational structures, was to explore how far diverse environments, memberships and core processes did indeed produce the predicted divergence of organisational structures; and how all the former produced diverse outcomes. This theoretical framework drove a qualitative maximum-variety sampling strategy. Our case study sites were purposively selected to cover the main NHOs and partnership structures in differing environments and with differing core processes. Hence we assembled a cross-sectoral sample of case study sites. In qualitative sampling the question of achieving statistical representativeness does not arise. Rather, our sampling strategy was to obtain cases that were typical in kind of the types of organisation we wished to study. That is, their organisational structures contained a substantial non-hierarchical component. We sought one example (case) of middling size and scope of activity in its field. We limited the selection to partnerships with three or more partners because a smaller partnership would be unlikely to have a developed relational democracy or subjoined hierarchy, indeed be too small to count as an organisation (207). The first strategy produced, as a first stage, a broad selection of study sites of which we would make relatively brief case studies. Our reasons for initially comparing health and non-health organisations were to explore:

1. As wide a variety as feasible within project resources of the memberships, governance structures and core processes that NHOs and partnerships accommodate; hence, a wide variety of the relationships between these elements.
2. Whether, how and why, these organisational structures and core processes differed across economic sectors, so as to throw into relief any differentiating characteristics of those in health sector.

The corresponding range of coordination and management problems which NHOs and partnerships face, and the range of solutions attempted. This work contributed to produced an initial set of answer to the descriptive elements of the research questions stated in the brief besides laying the groundwork for stage 2. Following a 'funnelling' strategy for site selection we (selected about half of the stage 1 cases for more in-depth studies over a longer (i.e. two-year) period, a two-layer arrangement of case-studies is similar to that of (the Evercare evaluation (208). Since the research brief and questions explicitly concern health settings, we funnelled down in the second set of case studies to examining the health sector cases more fully. The longer duration, greater detail and larger number of informants in these case studies was intended to aid the gathering of data on informal organisational structures and to enable the case studies to narrate how

external changes or stimuli were perceived (or ignored) by NHO or partnership 'boundary spanners', how decision makers responded (e.g. what targets they set, what internal incentives they apply), how these events set in train further organisational processes, and to what effect on services.

4.3.2 Site selection

We identified possible study sites by consulting the relevant academic departments in the applicants' institutions, the researchers' existing networks of relevant contacts and searching the websites and publications of such sector-wide coordinating bodies as Mutuo and CABs, the DH website and the professional press. From the NPCRDC database we were able to identify a small number of PCTs with a relatively wide variety of general practices and other providers, and this suggested a number of PCTs whose websites we checked and to whom we made telephone enquiries seeking information about whether their general practices included any with salaried doctors employed by the PCT. In fact several of the PCTs contacted had difficulty supplying such information. We contacted 23 organisations of which, after various refusals, 12 agreed to participate in the study. More than we had expected the choice of study sites was constrained by availability (what types of organisation actually existed at the time of study), visibility (which of the available existing organisations were visibly identified as partnerships or NHOs in the sources mentioned) and access (which of them were willing to be study sites). In general, professional partnerships were harder to access than other kinds of (organisations. In some cases (e.g. general medical practices with a manager as partner, PCT-managed practices) it took visits to several sites before we found one willing to participate. In one non-health NHO we had just started interviewing when the organisation lost a local authority contract and our main contacts were made redundant. Few consumer cooperatives exist in the UK health sector. We approached one of the largest but they declined to participate (no reason given). We therefore initially proposed to study a New Zealand IPA as an instance of this category of NHO since these IPAs are part of a health system quite similar the English NHS. We therefore sought the advice of academic colleagues currently working in New Zealand and contacts in the New Zealand Department of Health as to whether these IPAs would be suitable study sites, and if so how to access them. These enquiries and the New Zealand Department of Health publications suggested that the character of the New Zealand IPAs was not quite what certain policy documents suggested. Although these IPAs were supposedly intended as community-controlled, co-operative like bodies for commissioning local primary care services, closer enquiry suggested that in reality they are much more like the medically-dominated Primary Care Groups found in England during 1998-2001 i.e. a network of general practices with a relatively egalitarian but professionally dominated co-ordinating body. In consultation with SDO we therefore abandoned the idea

of studying a New Zealand IPA and investigated whether it would be realistic to study a patient and consumer cooperatives in the Netherlands. That however would require a native Dutch speaker to do the fieldwork. Even in the Netherlands there are few experts in this field and the four whom we contacted were already fully committed. We therefore approached a prominent consumer cooperative in the USA which, as following data showed, proved to be a study site well suited to the purposes of the present project. These methods and contingencies resulted in the selection of the following case study sites, here pseudonymised to comply with the conditions of ethical approval. Fuller background descriptions are in Appendix 1.

NHOs, non-health:

A) 'Wholefood': Whole-food producer, retailer and cafe

B) 'Bigshop': Retailer, household goods

C) 'HouseLend': Mutual building society

Partnerships, non-health:

D) 'Legal': Legal partnership

E) 'Architects': Architectural partnership

F) 'Accountants': Accountancy Partnership

Partnerships, health :

G) 'NurseLed': Nurse-led general practice

H) 'PlusPM': General practice with manager partner

I) 'PharmPlus': General practice with pharmacist partner

NHOs, health:

J) 'OverThere': US consumer cooperative commissioning health services

K) 'Metro': GP out-of-hours cooperative

L) 'City': Social Enterprise providing out-of-hours and other primary care services

Besides the 12 main sites we collected data for comparison more restricted data focusing on structure, origins and market strategy at a PCT-managed general practice ('PCTrun') and three corporate primary care providers, one ('WasCoop') a de-mutualised out-of-hours cooperative. To check that the selected study were sites typical of their respective types of NHO and partnership in terms of populations served we compared the characteristics of the population they served, as described in GPPS data, with the English averages. It so happened that our one of two OOH cooperative study sites served all but two general practices in the three PCTs that it served ((98% of practices there) and the other served all practices. By combining PCT-level GPPS data for each set of three PCTs it was therefore possible to

produce approximately equivalent comparisons for the two cooperatives. The data are in Appendix 4. Because GPPS is a survey of general practice users a clear majority of its respondents are women. Both in large cities, the two cooperatives served a somewhat younger, more ethnically diverse population than the generality of English primary care users at the time. For all the relevant population characteristics, the practices (taken together) and the cooperatives (taken together) were distributed either side of the England mean. This is weak evidence that, taken together, the study sites were not markedly qualitatively atypical of those in England as whole. This is at least a necessary condition for making cautious qualitative generalisations from any patterns found across the study sites taken together.

4.3.3 Data collection

In all the study sites an initial exploratory study began with interviews of a small number of (key informants, typically four to six per site including the chief executive, senior partner or equivalent; a 'boundary spanner' and one person involved in the organisation's core activity (healthcare, audit etc.) of the organisation. For the in-depth health organisation case studies we collected data by interviewing doctors, managers and nurses, observation of meetings, in reception areas and offices, and content-analysis of documents collected on site or on-line. Data collection over two years allowed us to observe at least one annual financial, planning, production and reporting cycle. In all we conducted 146 interviews and collected 631 documents ranging from patient leaflets, spreadsheets and web-pages through annual reports to one full-sized textbook (the official history of the health consumer NCO). We monitored the main professional (as opposed to peer-reviewed) periodicals such as Health Services Journal and Pulse for relevant news items (cp. (70)). We recorded how the study organisations experienced external, (especially commissioners', governance and incentive arrangements. To describe the other side of these relationships we also interviewed informants from the commissioners, including those responsible for promoting and then influencing, new kinds of partnership and NHO. We examined user experience by using documents and interview data to map (cp. (209)) the main sequences of patient care.

The QPID data-sets mentioned in the original research proposal were superseded after 2004 for most primary care services (and for the remaining two therapy services after 2005). NPCRDC's Tracker survey, which would have been a valuable source of such data, had also been discontinued at the start of the study period. PACT data are not publicly available. Originally we proposed to undertake randomised sample surveys of English study site patients. Patient surveys however became mandatory and NHS service providers were generally implementing them by the time of our fieldwork. Since it was pointless to duplicate this activity we decided in consultation with SDO to use instead the survey data that were (already being collected and the nearest publicly available replacements for the

discontinued data sets. General Practice Patient Survey (GPPS) and Quality and Outcomes Framework (QOF) data were therefore downloaded from the NHS Information Centre at www.ic.nhs.uk/statistics-and-data-collections/supporting-information/primary-care/general-practice/gpps-2007/08/gpps-2007-08-data-tables and www.qof.ic.nhs.uk respectively, and used to contextualise the study sites in terms of their performance compared with England average scores on the outcome-related data sets relevant to the research questions. These data were not used as outcome measures by which to compare outcomes of different types of organisation (a methodologically suspect approach) or of the particular sites (uninformative) but as a way of checking whether in terms of those outcomes the study sites were typical of their kind.

Interviews were tape-recorded with permission and transcribed. Field-notes were taken during site visits, cleaned and anonymised (210). We used theoretical memos (211), often e-mails for discussion, to trace the development of our thinking during the research. Data collection was iterative in the sense that a common interview schedule was consulted before each interview or site visit. Setting aside any topics on which we already had data, the researcher selected which general questions in the interview schedule the prospective interviewee would best be placed to answer, at need supplementing them with more specific sub-questions or probes formulated in light of our accumulated knowledge about the site, so as to elaborate or check emerging themes and findings. When unforeseen kinds of data appeared the researchers supplemented the data grid (and hence interview schedule) with additional sub-categories. We also supplemented our original data grid and interview schedule with categories suggested by (emerging from) the systematic literature review. In those senses data collection by interviewing was iterative (212).

The data so collected were used to populate field grids (Appendix 5: one per site) structured to reflect the environment-structure-process-outcome framework and theories outlined above. After fieldwork we checked our findings at two levels. At individual level, interviewees were invited to see and as necessary correct transcripts. (Many did.) At organisational level, we invited our main contact at each study site to correct any factual errors which they might find in the completed case study.

4.3.4 Data analysis

To test the above theories and concomitant taxonomy it was necessary first to collate the case study data under the categories of the initial theoretical framework. Use of a standard data grid for all sites achieved this. It also revealed any gaps in the data or apparent contradictions between different data sources. Supplementary data could then be collected to resolve these uncertainties ad hoc, often by e-mail or telephone enquiry. By triangulating the data so collected we built up narratives for each site describing partnership and NHO structures and internal organisational arrangements;

their goals (explicit and implicit), why and how they were established; how they were coordinated and what made for a successful co-ordination strategy; the key elements of management in any subjoined hierarchy; how professionals within them interacted and regulated themselves; and what governance and incentive arrangements external bodies placed upon these organisations and to what effect. In that way each in-depth case study described how the organisation's environment, structure and processes produced (or stymied) the policy outcomes of interest. Cross-case comparative analyses followed the assembly and analysis of each individual case study (213). Our sample of sites allowed us to compare the empirical similarities and differences between:

1. NHOs and partnerships (e.g. primary care partnerships and primary care cooperatives).
2. The different kinds of NHO (e.g. NHOs in different sectors; producer and consumer NHOs).
3. The different kinds of partnership (e.g. in different sectors; medical versus nurse-led partnership).

Partnership-owned and PCT-managed primary medical care. The initial round of case studies, across all the sites, was intended to provide an overall narrative of how each organisation developed, how it was structured and managed, and what differences there might be between nominally similar organisations within and outside the health sector. In a second phase, the six health sector case studies were elaborated with interviews at the level of front-line (clinical and care) staff, and by the inclusion of publicly-available routinely-collected data about the services provided, (their outcomes, and survey data about patients' responses to the services. The second-stage case studies thus attempted to examine more fully the connections between organisational structure and service delivery.

4.4 Combined analysis

For each main element of the above theoretical framework we next combined the empirical findings from the systematic review with those from the case studies. Our main method of analysing the combined data was to induct patterns across the two main types of evidence. The combined data grounded more robust empirical generalisations than the case studies alone could supply. By combining primary and secondary sources we were also able (to compare (indeed check) our own findings against those from other studies. We combined the two kinds of empirical findings about organisational environment, and within that heading collated review with case study findings about organisational membership, formation, external dependencies and goals; and so on for the rest of the theoretical framework. (We supplemented or corrected our original theoretical framework where it proved insufficient to accommodate patterns emerging from the combined data. Our theoretical framework implied that the

patterns found in partnerships and in NHOs would differ, as would the patterns found in different variants of organisation within these two main categories. We therefore systematically compared the different types of organisation research question by research question. Our sample of study sites allowed us to make cross-case comparative analyses (213) of the empirical similarities and differences between:

1. NHOs and partnerships (e.g. primary care partnerships and primary care cooperatives)
2. The different kinds of NHO (e.g. NHOs in different sectors; producer and consumer NHOs)
3. The different kinds of partnership (e.g. in different sectors; medical versus nurse-led partnership)

Partnership-owned and PCT-managed primary medical care. Terms such as 'successful' involve normative assumptions. We assumed the criteria of 'success' were:

1. Achieving the founding goals of the study organisations.
2. In light of the predictions of organisational 'degeneration', sustaining the eqalitarian and democratic ('non-hierarchical' and 'partnership') character of the organisation.
3. Realising the health policy outcomes stated in the research brief (securing professional engagement; maintaining clinical job satisfaction and morale, and hence the (corresponding level of workload; developing clinical quality, best practice and innovation; adherence to external performance targets; cost-effectiveness of service provision; satisfactory patient outcomes and experiences).

Research questions about the 'success' of organisations were therefore answered by making a normative comparison (214) between data about the organisations' characteristics or activities and the criteria listed above.

The methods of analysis shown in Table 4 were used to produce findings in answer each research question.

Table 4. Methods and findings

Research question	**Method of analysis**
1a. What are the goals (explicit and implicit) of such organisations and why/how are they established?	1. Induction of patterns of goals reported across the systematic review and case study evidence. 2. Narrative accounts of organisational formation.
1b. What is the nature of the governance and incentive arrangements that are placed on these organisations from external bodies? Is	1. Induction of patterns of external governance reported across the systematic review and case study

there an effective form of regulation, and if so what is the nature of this?	evidence. 2. Narrative accounts of responses to external regulation.
2a. What are the structures and internal organisational arrangements of NHOs and partnerships?	Induction of structural patterns reported across the systematic review and case study evidence.
2b. How are professional partnerships and NHOs co-ordinated, and what makes for a successful co-ordination strategy? (	1. Induction of patterns of managerial practice (reported across the systematic review and case study evidence. 2. Comparison of these strategies and their outcomes with normative criteria of 'success'.
2c. What are the key elements to the internal management of such organisations?	Induction of patterns of managerial practice (reported across the systematic review and case study evidence.
2d. How do professionals within such organisations interact with each other and how do they regulate themselves?	Induction of patterns from self-reports of professionals in the case studies and from secondary reports of effects of changes in professional self-regulation.
2e. How do such forms of organisation impact on securing professional engagement?	Induction of patterns from self-reports of professionals in the case studies.
3a. How do such forms of organisation impact on clinical workloads, job satisfaction and morale?	For health sector case studies only, induction of patterns from self-reports of professionals
3b. How do such forms of organisation impact on the development of innovative practice?	Induction of patterns of, and reasons for, service innovations from self-reports of professionals in the case studies and from secondary reports.
4a. How do such forms of organisation impact on clinical quality and development of best practice?	For health sector only: 1. induction of patterns of innovation reported in case studies and systematic review. 2. Synopsis of publicly available

	clinical process and outcome data.
4b. (How do such forms of organisation impact on adherence to external performance targets?	For health sector only: 1. induction of narratives of organisational responses to external targets. 2. Synopsis of publicly available administrative data.
4c. (How do such forms of organisation impact on the cost-effectiveness of service provision?	Induction of patterns of costing and pricing policies, and of financial constraints, reported across the systematic review and case study evidence.
4d. (How do such forms of organisation impact on patient outcomes / experiences? (	For health sector only: 1. induction of patterns of systems for patient influence upon service design and delivery. 2. Synopsis of publicly available patient survey data.

The environment-structure-process-outcomes (ESPO) framework holds that an organisation's environment gives rise to the organisation itself and its goals, to pursue which an organisation structure is created. The goals and structure operate a core process which literally produces outcomes which may or not satisfy the original goals. Environment, the organisational goals arising from it and organisational structure can thus be thought of as a set of initial conditions, process and outcome as what emerge from these initial conditions. A further way of testing the theoretical framework was therefore to find out how far these assumed initial conditions did in fact exist, on the basis of the combined evidence. Insofar as the initial conditions did empirically obtain, we then examined whether, judging by the combined evidence, they did indeed generate the processes and outcomes which the aforementioned theories predict. We empirically tested the theoretical framework thrice over:

1. In each site the case studies reconstructed the ESPO sequence(s) which produced (or not) the policy outcomes stated in the research questions and other outcomes predicted in the theoretical framework or published theory. Then we compared these observations with the relevant parts of the theoretical framework. Single-site analysis served three purposes:
   (a) Taking each site as a qualitative exemplar of one type of organisation, it could test the relevant theoretical assertions for each type of organisation studied (215).

(b) One counter-example can falsify a claimed universal causal relationship (204).

(c) One example is sufficient to provide proof-of-concept, showing that a particular type of organisation is practically feasible.

2. Across sites (cases) we compared the ESPO sequences for each policy outcome of interest. The standardised data grids allowed systematic comparisons, revealing patterns of similarity and differences which could then be compared with the theoretical framework outlined above.

By testing the theoretical framework assertion by assertion against our combined primary and secondary evidence. We compared the data against theoretical assertions and assumptions in a falsificationist way, looking for any empirical patterns necessitating rejection or revision of theories or assumptions found in the literature or our own initial theoretical framework. These methods enabled us to verify some and correct other parts of the above framework of 'middle-range' theories.

4.5 Advantages and limitations of the methods used

Because this was an exploratory nature of the study we made initial case studies of a wide variety of organisations. This is both an advantage and a limitation methodologically. The advantage is that a wide selection is likely to reveal a wide range of possible organisational structures, which is of value in considering new health policy possibilities. The multiple comparisons which become available also allow the analyst to abstract from different organisational characteristics. For instance by comparing, say, partnerships with different memberships one can abstract from differences in the organisations' legal personality and focus on the organisational differences (if any) produced by the difference in membership. The disadvantage is that any more widely generalisable findings have to be produced by qualitative generalisation and therefore have to be taken with caution. The present study works with middle-range theory. It investigates relationships among a subset of variables from wider theories (see above) 'in the hope that, if empirically validated, more comprehensive theories might proceed' ((59); p.140).

The selection of study sites allowed us to focus development of the above theoretical framework on the health sector, at the price perhaps of empirically neglecting other sectors (e.g. housing, consumer credit, distribution of farm products) where NHOs also exist. By its nature an exploratory study also aims to study organisations sites which may prove a source of ideas for innovations in organisational structures; hence, sites which are (only) in that respect exceptional.

Case study methods are open to recall bias insofar as they rely on informant interviews, and to bias towards self-justification by informants (and documents). One might expect this risk of bias to be greatest when clinicians, managers or member-representatives describe the benefits of

their services to patients or commissioners. Triangulation of data sources, especially data sources external to the study organisation, can reduce these dangers. The documents we collected included marketing and public relations materials. If their claims conflicted with other sources we gave the latter credence. With these precautions, however, the actors' recollections and eyewitness accounts are valid - nay privileged - sources of explanation of organisational formation, goals and working practices.

We have made no formal CEA. It might appear that GMS payments, being standardised, remove price competition from the quasi-market for NHS primary medical care services in England. However this does not make it possible to compare the cost-effectiveness of general practices by examining which kinds give larger or better real-side outcomes for their standardised payments, because these payments are through a QOF points mechanism intended to make the payments reflect the outputs or outcomes produced. Comparison of QOF data is thus informative (within the limits of the data and of the indicators chosen) about effectiveness but not cost-effectiveness.

We compared certain characteristics of the study sites against national patterns, but solely in order to assess the apparent qualitative generalisability of our findings. NHS-ICS recommend that national QOF data should not be used to construct 'league tables', in the present case by (invalidly) comparing the putative merits of the different organisational structures and management practices across our study sites. The same applies to GPPS data. Beyond suggesting how far our qualitative findings might be generalisable the publicly-available data sets mentioned above were indeed of little use to this study. The crucial omissions were that data-fields for salaried GPs did not distinguish between GPs employed by partnerships from those employed by PCTs. Data-fields for PMS practices did not distinguish between PMS practices directly managed by PCTs and independent partnerships under a PMS contract. Neither did published data on GP payments (e.g. (216)) and workloads (217) so discriminate. Indeed, fewer data-sets on these points were publicly available than in 2004-5 when the present research proposal was written. Without being able to compare these subcategories, tests of association between such variables as information for patients, staff training, medical records and medicines and management, and practice management (on one hand) and clinically related QOF outcomes (on the other) generate little information of value for the analysis of organisational structures. A supplementary census of PCTs would be required to differentiate practices in the necessary ways.

4.6 Ethics and research governance

Ethical approval was complicated by the fact that both NHS and non-NHS sites would be studied. NHS REC approval was required for the NHS sites and University of Plymouth approval for all sites, the latter being conditional upon REC approval. NHS approval was obtained from North Staffordshire

REC (ref: 06/Q2604/153) and then from Plymouth University ethics committee. For NHS sites research governance clearance was then obtained site by site, which for general practices meant gaining approval from the practice and its PCT. We conformed to the same ethical requirements in researching non-NHS as the NHS sites.

One condition of ethical approval was that we anonymise findings and quotations unless we had consent to do otherwise. Three of our study organisations waived their right to anonymity but for consistent presentation we have retained pseudonyms throughout. In describing small organisations, pseudonymisation requires care. A pseudonym such as 'phlebotomist, site A' is easily seen through if despite our efforts site A's identity is worked out and it has only one phlebotomist. For informants who made adverse comments about colleagues or their organisation we would in any event use uninformative pseudonyms (such as 'employee A'). For consistency we have applied the same role to all informants even though that removes information which might otherwise contextualise their remarks.

5 Systematic review findings: professional partnerships

In presenting our systematic review findings we follow the ESPO sequence described above, treating professional partnerships and non-hierarchical organisations separately.

5.1 Environment

The practical advantages of collaboration are evident in most professions ((218); on law, see Greenwood, Hinings, and Brown (103); for medicine, see Casalino et al. (219)) although their training and early career tend to prepare professionals to work more on an individual basis. McNair (220) reports that even during professional training, re-adjusting from individual to team working may provoke a 'tribal' reaction when professionals feel threatened by others who they view as encroaching on their territory. Professionals working in partnerships obviously have to accommodate to requirements of the partnership as a whole, unlike the solo professional (221). Against this, Cooper et al. (71) describe the unproblematic coexistence of managerial and professional ideologies amongst law firm partners. Predominantly, though, published studies examine the economic motives for partnership formation.

A partnership shares profits between members (222). Therefore incentives in the form of individual reward appear to be an important consideration when professionals decide the best form of organisation or partnership to join (223). A few studies (224,225) explain partnership formation in terms of financial and tax advantages. A study of 119 large and medium-sized consulting firms found that the significance of capital requirements, service standardization, business risk, and organization size endogenously determined the allocation of ownership rights in these firms (226). Casalino et al. (219)found that a lack of doctor cooperation, investment and leadership were the most frequently cited barriers to large group practice. Based on information derived from 195 interviews conducted between 2000-2001 and information on group trends in group size obtained from more than 6000 doctors in private practice in 12 randomly selected metropolitan areas via telephone surveys, this US study found that gaining negotiating leverage with health insurance plans was the most frequently cited benefit to increasing group size. The study concluded that current payment methods rewarded gaining size to obtain negotiating advantage more than they rewarded quality. Bodenheimer et al. (227) and Conrad et al. (228)also suggested that US hospitals and doctors were increasingly consolidating and merging in their search for economies of scale and contracting leverage relative to private health plans. More risk averse doctors, especially in small practices, appeared willing to sacrifice about

10% of their income as a concomitant of risk spreading (101). The substantial barriers to creating large medical groups meant that most private doctors continue to practice in small groups, although the size of these groups is slowly increasing. The benefits of obtaining a more equal balance of power appear in one case (out of sixty English partnerships in that study) where a large external client was able to stipulate what internal monitoring and planning arrangements a legal partnership should adopt (86).

Lang and Gordon (102) start from the assumption that professionals make a significant investment in their human capital and such investments are risky as there are no capital markets in which to sell this asset and no available forms of insurance. One explanation for the existence of partnerships therefore they maintain is their role as a risk sharing or insurance mechanism. Here partnerships are perceived as mutual insurance associations in which partners join together to insure themselves against idiosyncratic shocks to their human capital. This they argue generates a trade 'off between efficiency and risk sharing as it is assumed that since partners retain only a proportion of the profits that accrue, they will contribute less than optimal effort. Based on an analysis large scale empirical survey they show that in equilibrium, participants in larger legal partnerships in US law firms keep a smaller share of their own proceeds than smaller partnerships; larger partnerships share profits more fully among partners. This they argue provides empirical support for the view that partnerships are designed, at least in part, to provide insurance. Like Lang and Gordon, Gaynor and Gertler conceive partnerships as a classic organisational response to the trade-off between risk spreading and moral hazard and the extent to which firms choose to spread risk and therefore sacrifice efficiency incentives depends upon risk preferences. They note that institutional economics literature suggests several reasons why doctors organise in partnerships: to exploit economies of scale; to internalise referrals, to smooth work schedules, to exploit reputational economies of scale and possibly to collude against competition. Their econometric analysis of US data derived from a sample including 415 medical groups and 1,230 doctors practising in these groups. The study found evidence to support the theory that firms adopt 'second-best' incentive structures in order to spread risk. In particular, increased risk aversion leads medical partnerships to choose compensation arrangements less closely related to doctor productivity and to decrease the number of doctor members. They also found that incentives had a strong positive effect on doctor effort. For an average sized group, moving from compensation unrelated to productivity to a compensation completely related to productivity more than doubles output. More risk-averse doctors form smaller partnerships with greater non-medical staff input (101).

Lang and Gordon (102) propose that because they offer a continuous, professional service in order to reduce the likelihood of claims for malpractice, GP partnerships might also be viewed as mutual insurance

associations in which doctors band together to insure themselves against loss of both human and monetary capital. For unlimited liability places the partners at risk of financial ruin in the case of a claim for medical negligence by a patient. Strong partnership ties also provide a strong signal of each partner's belief in their own and their colleagues' ability (222). US clinicians are able to insure themselves against litigation through malpractice insurance premiums. However these premiums are not experience rated so a doctor who has often been sued for low quality care may pay no higher premium than doctors who are sued less frequently (128). The Lancet (2005) suggests this factor may be of relevance in the modern NHS, where patients are encouraged to complain more in order that the service can be improved. Thus deliberations about economies of scale and projected financial outcomes may determine whether or not a partnership is formed, as would consideration of financial risk sharing between partners.

Levin and Tadelis (222) develop an economic model to show that organising as a profit-sharing partnership can alleviate problems in situations where it is difficult to assess service quality and firms are prone to hire suboptimally low ability workers. In markets where clients may not be able to monitor quality well partnerships emerge as a desirable form of organisation for addressing client needs. If however the assumption of equal sharing in partnerships (that is all partners have the same objective) is relaxed, the structure of decision rights and how partnerships are governed becomes an important area for future research.

Bodenheimer et al. (227) and Conrad et al. (228) also suggest that US hospitals and doctors can be seen to be increasingly consolidating and merging in their search for economies of scale and contracting leverage relative to private health plans. More risk averse doctors, especially in small practices, appeared willing to sacrifice about 10% of their income as a concomitant of risk spreading (101). The substantial barriers to creating large medical groups meant that most private doctors continue to practice in small groups, although the size of these groups is slowly increasing. A study of 119 large and medium-sized consulting firms also found that the significance of capital requirements, service standardization, business risk, and organization size endogenously determined the allocation of ownership rights in these firms (226).

Getzen (6) sets out a 'brand name firm' theory of medical group practice which arises where the quality of output is highly variable and the costs of quality information much greater for consumers than producers. Then patients depend upon provider reputation and are willing to pay a premium for 'brand name' quality services. The advantage of group over solo practice is that to some extent internal evaluation by medical colleagues can substitute for more costly patient search in monitoring quality. Thus patients and reputation can be transferred more efficiently and brand name can be created at less cost. Group practice is more common where population mobility is higher (in theory because costs of search are higher for patients in such settings and so a 'brand name' saves patients more

costs). In the Netherlands, however, partnerships of independent doctors with hospital admitting rights are becoming a thing of the past as hospitals negotiate with sick funds on behalf of the doctors, a deliberate policy to integrate these doctors into hospital structures and attenuate the partnerships' power to obstruct change (229). A survey comparing group and single-handed general practices in the Netherlands indicated what doctors might gain by joining a group practice. The latter had more extensive infrastructure, more computerized medical information and more quality assurance activities although patients gave single-handed practices higher marks for service, accessibility and even for the facilities. Single-handed GPs worked more and had higher levels of job stress, but perhaps also more autonomy at work (230). The demise of partnerships also gives clues as to what motivated their foundation. Empson's study (231) of the takeover of one English accounting partnership by another suggested that a larger partnership was more likely to take a managerialist approach to its day-to-day operations, have a less traditional interpretation of professional identity and (depending on the circumstances) value different professional skills than its predecessor did. Denning and Shastri (224) examined the consequences for shareholders of a change in organisational form from a corporation into a limited partnership. The study used longitudinal data about 53 firms in the United States that announced either complete conversions or spin-offs of units into limited partnerships during 1980-1989. The announcement of a plan to create a limited partnership was associated with an increase in stock price. The stock price impact of a conversion did not appear to depend on whether the conversion is partial or complete, or defensive. The authors interpret these findings as evidence of positive economic benefits to shareholders when conversion from corporate to limited partnership form is anticipated. Citing two rather old studies (232,233), Getzen (6) states that 25% of US group practices cease to exist after 10 years with disagreement over income distribution being the main cause. A panel study of doctors in one large US corporation (87) suggested that doctor's length of service in an organisation did not reflect organisational commitment but this finding applied to an employed doctors besides partners.

5.2 Structures

5.2.1 Modes of democracy

Various studies describe a rather relational form of democracy amongst professional partners. Managing and senior partners are usually selected by consensus or election, perhaps with a central board (or equivalent) undertaking (in descending order of likelihood) monitoring (especially financial monitoring), corporate planning and operations-monitoring roles. In large legal practices a committee of partners is often elected to take on managerial work. Crucially, their authority is derived from the partnership as a whole. Founder members tend to have largest equity and greatest

status internally. Therefore the organisational hierarchy in partnerships may be said to be inverted with an executive committee being formed to serve the partnership in strategic operational decision-making (86). Typically, the partners in Canadian accounting firms annually elect an executive committee and more specific working committees. Partners at the national or international office frequently returned to their former roles after serving one or two terms (103).

Profits in those firms were distributed pro-rata to partners' numbers of shares; and the latter reflected length of service, type of clients, revenue-generation, responsibilities within the partnership (103). In contrast, most US medicine is in group practices with undifferentiated ownership rights. Non-medical and fixed costs are shared equally between partners. New members are soon promoted from salaried to partner status. US partnerships tend to have group decision-making and resource allocation (101). So far as we are aware no equivalent English data have been published.

Restratification of the profession, i.e. the emergence of a stratum of GPs who, although they remain mostly partners within professional partnerships, mediate the relationship between (on one side) government and health system managers and (on the other side) professional partners, has also been reported in Canada and England (234-237).

5.2.2 Mutual scrutiny

Studies of legal partnerships belie some micro-economists' predictions (see above) about the likelihood of shirking ('free riding'). Lazega (129) describes a large US law firm where partners' work was documented and open to all other partners, so that under-performance soon became apparent. A partner would be selected to talk a deviant or under-performing partner back into line. Partners chosen to speak to infractors tended to be of similar role (same office and legal specialty), to have equal or greater seniority or status than the infractor, to have some prior connection with the partner, and to have control over employees (but not necessarily other resources). Lazega and Lebeaux' ((67) study of law firms found that relational control of one professional by another was often undertaken through a third professional, most often one who was a counsellor rather than collaborator or friend of the professional first raising the problem. Partners used friends to influence other friends among the partners, collaborators as intermediaries to influence other collaborators, and counsellors to influence other counsellors. A partner trying to influence another partner with whom he had close working ties would generally select a mediator who had only impersonal ties to the person whom the first partner was trying to influence. Cooper et al. (71) describe a law partnership which employed non-lawyer manager and IT systems to help partners review each others' performance. In a minority of the 60 UK law partnerships studied by Pinnington and Morris (86) operations monitoring

involved scrutiny of partners' working practice. This was the largest departure from traditional autonomous role of a partner. Even in these sites, the practical need for individual partners to retain flexibility and discretion in dealing with clients (see below) limited the scope for that monitoring.

Clinical governance in NHS general practice shows parallels with Courpasson's concept of 'soft bureaucracy' Influence is not exerted through 'hard' managerial tactics like hierarchical supervision, disciplinary measures and the like but more sophisticated strategies such as hints of the risk of non-medical managerial intervention (238). Hence formal organisational structures played little role in obtaining adherence to external performance targets via clinical governance. Clinical quality was mostly managed by semi-formal networks that relied on collective medical self-surveillance (239).

5.2.3 Ideology and culture

Working teams are more effective when people with similar attitudes are grouped together, than when the team includes diverse-thinking individuals (240). Drawing on an in-depth case study of the management controls used in the Nordic subsidiary of a global management consultancy ('Global') employing roughly 800 people, Alvesson and Karreman (241) question traditional ideas about the existence of pure forms of organisational control and the assumption that technocratic and socio-ideological controls are mutually exclusive. Global was viewed as strongly 'partner centric' and partners were perceived to have a strong control over the business. Global achieved a high level of compliance, including a readiness for staff to work very long hours and meet very ambitious targets and deadlines. Different forms of technocratic control interacted and merged with socio-ideological controls in an organisational context to produce a high performance workforce. In particular, formal systems of checking and audit directed attention and encouraged a particular outlook and mentality and in this way the formal control structures, although intended to alter behaviour and outcomes, also exercise cultural control. A recent analysis of 46 cases of new partnership creation in consulting and law firms suggested that the legitimations required for radical diversification of partnerships are very different from those required for incremental diversification (242). A study of 10 Netherlands veterinary partnerships suggested that professional partnerships tend to have a clan culture with elements of 'adhocracy', but not a strongly market-oriented culture (243). A study of 18 US medical practices suggested an absence of coherent cultures there (244).

In English general practice two main cultures have been described: 'holism' which legitimates general practice in terms of the needs of the 'whole' person (245) and more recently a culture of 'bureaucratic' medicine (144,145) which emphasises the scientific, evidence-based character of general medical practice. Jones and Green (246) also describe an emerging

more democratic and informal culture. General practices with better team climate showed greater continuity of care (247). Another multiple case study suggested that changes in the GPs' contract led to the emergence of a culture in which lead GPs were 'chasers' (and other partners the 'chased') in pursuit of the new contract targets (38). The blurring between professional and commercial cultures reported in legal partnerships (see above) also began to become apparent in English general practices(248,38).

5.2.4 Hybrid structures

Professional partnerships are apparently becoming more hybrid in structure. Even over the three years 1994-97 English legal partnership sizes in one study rose from a mean of 12 to 14 but support staff increased faster, from 49 to 60 (115). A similar pattern is observed in English general practice (249). In the large Canadian accounting firm, partners tended to manage other professionals at local level. Each local office had an 'office managing partner' but this structure was still less centralised than in corporations. Although central bodies existed to deal with most aspects of operations they only did so at lower bodies' request and focused only on critical functions (103).

Because of the managerial implications of such changes in partnership size and firm composition, Pinnington and Morris (115) propose that the traditional archetype of the professional partnership (called 'P^2' by Greenwood et al. (103)) has changed into a more 'business-like''managed professional business' (MPB). The latter introduces, rationalises and bureaucratises the strategic planning and detailed target setting, defining performance more in terms of pre-defined quality standards. In English legal partnerships these bureaucratic activities were concentrated in 'market-facing' parts of the partnerships and undertaken more by employees than by partners. Accounting partnerships differed little from non-partnerships in their use of marketing and finance controls, but in the partnerships the setting of local targets was very negotiative and decentralised. For example there were no fixed targets for market share. Accountability was tolerant and strategic direction weak compared with multi-divisional firms and holding companies, with heavy reliance on collegial control. In Canadian law firms, a focus on targets paradoxically gave local offices greater freedom in other matters. The planning horizon emphasis remained short-term, typically for one year at a time. Williamson (53) suggested partnerships operate under market and financial control as M-form organisations. They design performance targets, connect resource allocations to such targets and link compensation and bonuses to target attainment. This may be problematic for medical partnerships as many targets are short (less than one year) rather than longer term. Thus the effectiveness of medical partnerships is usually monitored through monthly, quarterly or annual business reports (86). Cooper et al. (71) stress that the MPB model is not the adoption of wholesale corporate practices by partnerships, rather the introduction of management systems to guide

professional activity at a higher level of aggregation. In the transition to MPB, collegiality declines, tenure becomes conditional on performance and there is less consultation between partners. In such partnerships, partners and employees would interpret events in ways which avoided the two discourses ('P^2' and 'MPB') confronting each other. In the accounting partnerships which Greenwood, Hinings, and Brown (103) studied, management consultancy sub-divisions were growing rapidly and in tension with the partnership approach used very different (more corporate) language and concepts. The underlying form of ownership prevents radical departures from the partnership to a managerial model. Partners retained control of client selection (and recruitment) and core production process (115). A minority of partnerships adopted a corporate-planning approach to management but only where equity ownership was concentrated did managerialisation proceed very far (86).

Debate continues as to whether these changes are more accurately portrayed as one 'archetype' replacing another or as the 'sedimentation' of one organisational structure upon another (71,115). Whilst the explanatory value of the 'sedimentation' metaphor has been disputed, the empirical pattern is not. These organisations continue to be controlled by the partnership element with its values of collegiality whilst the subjoined hierarchy continues to grow faster than the partnership element.

In NHS general practice, the increased availability of funding has led to the recruitment of more professionalised managers and more extensive, diverse support staff employees. Fundholding practices were more likely to have an externally recruited manager (250). After 2001 practice managers were increasingly required to implement guidance which affects all the partners (9). Despite the coming of the more complete 2004 GMS contract, it would appear that in some English general practices managerialisation has not gone as far as described in the studies above. None of the three general practices in Checkland's 2004 study (251) had any concrete plan for implementing NSFs and lacked much structure for dealing with incoming guidance. Use of a nurse to implement NSF was welcomed because it meant the practice could comply with what it regarded as legitimate guidance without GPs having to do the work themselves. Guidelines were welcomed if they made work easier, otherwise not. The practical impacts of guidance (on workload etc.) were more important to GPs than the effects on profession-wide autonomy and control. GPs responded to increasingly detailed guidance and guidelines by recording their clinical decisions more fully, even those who normatively opposed the increased 'bureaucratic accountability'. Some GPs recorded selectively, focusing on cases where more than one clinical decision might be indicated. Recording reduced GPs' scope for private, non-accountable self-assessment of their clinical practice (236). Nevertheless, there appears to have been little 'gaming' of the data which GPs returned to central government (252).

The 2004 GMS contract placed significant demands on practice management and there was confusion about what a practice manager's role

should be. Some GPs doubted their capacity to manage the practice managers and the latter had problems trying to 'manage' the GPs who employed them:

Both the managers in practice A and practice B commented on the difficulties associated with providing strategic management as the employee of a partnership. Ultimately, responsibility rests with the partners, and both managers felt that they were unsure how far their higher-level input could go. (251): p737

However the separation of managerial and clinical roles was maintained. Clinical matters belonged to the partners only.

Whilst not of partnerships, a study of 15 small owner-managed firms (where the relationship between employed manager and owners is similar to that in a partnership) found that the owner-manager relationship functioned most effectively when both parties conceptualised the competitive circumstances in similar ways and there was role clarity and complementarity. The effectiveness of owner-manager relationship depended on the expectations of those involved (whether democratic or authoritarian, depending on case). The relationship was more likely to work when both parties shared a clear vision (or both had none) and there was mutual respect and trust between the two parties (140).

A few studies describe transition from partner to salaried status. Thompson and Van de Ven (87) examined the personal transitions of 48 US doctors over three years as their private medical practices (group clinics) were acquired by a larger organisation. The study found that organisational changes perceived to be enabling to the doctor fostered compatibility between organisational and professional attachments. A key aspect of a smooth transition was the sense that the doctor could influence the change to which she was adapting; transitioning doctors were more likely to more likely to align themselves with the new organisation when they felt that their ideas were listened to, were involved in the change and retained some autonomy and discretion in their work.

In the USA Physician Practice Management Companies (PPMCs) act as a corporate partner, re-organising and consolidating medical practices to gain economies of scale, provide administrative support, provide capital for growth, and improve doctors' opportunities and bargaining power with payers. PPMCs include hybrid-structure organisations, and may be multi-speciality or equity model groups. They are typically capitalised by private venture capital firms. However, they retain some aspects of partnership. There are direct chains of command and communication channels between the managing doctors and partners. The PPMCs show a tendency towards adopting a more corporate approach, characterising medical groups as 'commodities' or 'business units' to be acquired or sold depending on their operating performance (253).

5.3 Process

5.3.1 Control of the core process

Greenwood, Hinings and Brown's study (103) of four of the eight largest Canadian law firms reported that 70-80% of the workforce were professionals, who did most of the core productive work. The core working process could not readily be broken down in a standard way into a set of discrete tasks and required discretion to undertake. A 'partner in charge' signed each audit off upon completion. Close links with clients also made accounting practices highly localised. Partners' focus and loyalty was to their local practice, not national or international head office. Hence even in the largest accounting partnership each local office ran almost like a self-contained firm. The central bodies focused on professional standards, training, new accounting practices, advice networks and inspection of work, including a rolling programme of detailed inspection in turn of the work done at each local office. Another Canadian study of accounting partnerships (254) showed that while auditors in them did have decision-making powers, their organisations' payment and decision-making policies ensured that partners' decisions were constrained by an interaction of professional and of commercial 'logics'. Conceptually this appears similar to the conclusions of Dowling, Wilkin and Smith (255) that NHS professionals and front-line staff in the NHS have authority and discretion to make decisions provided they are consistent with current policy.

Nevertheless, analysis of a panel dataset of top performing US security analysts over a nine-year period suggested the top performers did not 'own' their performance, even in this knowledge-intensive work. While an individual's past performance does indicate future performance, the quality of colleagues in one's organization also significantly affects top performers' ability to maintain their performance. Top performers in professional business services rely on high-quality colleagues both to improve the quality of their own work and to deliver it effectively to clients (256). In that sense, the partners' performance was an attribute of the partnership rather than of the individual practitioner.

A similar finding applies to complex projects and to the proprietary knowledge of certain types of partnership. Partnerships often set up matrix-like project teams for particular tasks. Lazega (123) cites examples from legal, industrial design, public relations and laboratory services partnerships. Fincham et al. (257) describe the 'sector knowledge' that management consultants accumulate which derives from repeated assignments in an economic sector, enabling the consultants to play the role of the outside expert whilst drawing upon language and experiences which the client shares. In health care, the rise of evidence-based medicine has deepened this distinction between publicly-available knowledge and the partner or partnership which applies it in practice. The rise of bureaucratic-scientific medicine produces a shift of work focus from individual

relationships with patients towards ways of treating care groups. Cross-sectional analysis of surveys of US doctors (258,259) found that IPAs (associations of independent partnerships) were the type of organisation least likely to undertake health promotion. Doctor-owned practices (by implication partnerships) were significantly more likely than IPAs to undertake health risk assessments for their patients (260). In England, policy guidance (NSFs especially) has to some extent homogenised clinical practice across general practices and, with the new contractual requirements have since 1990 shifted locus of general practice work to practice-initiated preventive work, not just responding to patient attendances; and increased the tension between these. Nevertheless, the three general practices in Checkland's 2004 study (251) each implemented the same guidelines differently, selecting different guidelines to implement, even different parts to read. GPs tended to think that guidance was for 'bad' practices not for them. External guidance had little practical impact on working processes. An earlier study found that, for example, some practices used 5-minute and some 10-minute consultations although the latter were correlated with better-quality chronic disease management (247). Jonsdottir et al. (198) argued that the Quality and Outcomes Framework (QOF) marked a shift towards standardized, commodified care increasingly measured and assessed by objective outcomes, away from the subjective experiences of care which Jonsdottir et al. regard as the relational core of nursing practice. Harrison and Dowswell (236) found that only 20% of the GPs in their survey thought they would not record their reasons for non-compliance with the new guidelines. Generally about two-thirds of innovations in English primary care were evidence-based, albeit on a generous definition of 'evidence'. Most of the rest were policy imperatives from outside the practice (261).

5.3.2 Substitution

In the USA (where medical partners typically have hospital admitting rights) changes in the technologies of patient care and improved information exchange mechanisms have shifted the dominant locus of care from hospital inpatient to outpatient settings (262). The capacity to link geographically dispersed care settings with electronic medical records has encouraged clinical integration among provider organisations (228).

Black and Weiss (263) attributed US medical partnerships' increasing collaboration with mutual aid organisations to the reduction in government funding for non-urgent medical services. The research focused on chronic, genetic diseases that required active patient or family and professional involvement for effective treatment and support on a personal level, including brittle bone syndrome, Huntington's disease and haemochromatosis. Through decreasing the need for health professionals on a day-to-day basis, the health service was able to save money. Black and Weiss further suggest that reducing the reliance on healthcare professionals and increasing the dependence on self-help groups can be more beneficial

to patients than them relying on medical support alone because self-help groups are better suited to deliver practical and emotional support to reduce the social and emotional isolation of those suffering from chronic, genetic diseases. However these models of care tend to become increasingly formalised because each party is required properly to understand and their specific role in it. Bodenheimer et al. (227) also predicted that financial pressures will promote the use of such models of care. Newton et al. (178) describe the failure to achieve close integration between an English general practice and community health services to the reluctance of the main external body (the PCT) to relinquish its responsibilities for the services rather than to any inflexibility inherent in the professional partnership involved. However another multiple case study(264) reported GPs as being reluctant to relinquish what they saw as their central role in the clinician-patient relationship and wondering whether inter-professional working would reduce their autonomy.

5.3.3 Size and economies of scale

The professional partnerships described in the published literature are mostly larger than the average NHS general practice with its mean size of just under four partners. The average size of English legal partnerships in Pinnington and Morris' 1996 survey (86) was 14 equity partners and 21 non-partner lawyers. One Canadian accounting firm had 490 partners (and 4000 employees). The biggest seven Canadian accountancy firms all had over 200 partners in 1987. All 60 firms in that study (20 accounting, 20 solicitors, 20 architects) had over 15 partners, tended to be multi-site. Some had offices abroad. A 1978 US national survey on medical practice data showed the average practice size even then as 21 doctors. More competitive local health markets are associated with larger practice sizes (101).

Economies of scale do not however appear to explain the larger size of US group medical practices (6). A US study (265) found diseconomies of scale with increased practice size, perhaps because increased practice size attenuates the effects of external productivity incentives. Conrad et al. (223) found decreasing returns to scale for capital inputs. More doctors than dentists in the USA (1976) were organised in group practices but dentists have greater opportunity to achieve economies of scale; which Getzen (6) takes as evidence against the economies of scale explanation for the formation of partnerships. Increased efficiency in the doctor-nurse-patient exchange is usually more important for achieving cost-effectiveness than economies of scale are. Conrad et al. (223) found decreasing returns to scale for capital inputs. Economies of scale due to capital indivisibilities exist only for groups of 2-7 doctors (but that is the size of most English general practices). Moral hazard (free riding) is larger in large practices, but with a decreasing rate of increase as practice size grows (101). In conjunction these studies imply that the economies of scale found when practices have fewer than 10 partners are soon exhausted. Defelice and Bradford (266)

suggest their economic modelling of the relative efficiencies of solo and group practices do not support the view that they operate at different levels of efficiency. Levin and Tadelis (222) suggest that partnerships expand their labour force less quickly than corporations. Partnerships hesitate to recruit new partners unless it is clear that new partners would maintain or raise the average partner's share nett of costs. Nevertheless Conrad et al. (228) argue that medical practice organisations are gradually reshaping themselves into larger, more formalised ownership structures ('multi-faceted metamorphosis'). It seems likely that a partnership will choose a partnership number threshold in a similar way to the way a corporation chooses an employment threshold. This is said to create stability within the organisation (222). Alliances with other organisations allow partners to assess whether they would be able to create new value if resources were pooled (267), and at what size diseconomies of scale and scope might arise. In the UK, access to most care seems better in small practices except for diabetes services (better access in large practices) (247).

5.3.4 Marketing

Increased pressures to undertake marketing can, it appears, strain the partnership model. Pressure to cross-sell each other's work undermined the collegial 'P^2' archetype (71). Similarly, pressure to sell legal services in the crowded Canadian market has led to greater reliance on advertising, marketing and franchising, creating an uneasy cultural mix of professionalism and commercialism (221). Doctor ownership of pharmacies is prohibited because of the grounds - 'apparently well founded' ((6); p.207n.12) - that doctors would promote unnecessary drug sales and raise prices. For similar reasons fee-splitting (one independent doctor paying another for referrals) is illegal in the USA.

5.4 Outcomes

5.4.1 Productivity

Richter and Schröder's (226) study of 119 consulting firms found that ownership allocation per se was not a significant driver of performance. Mathijs and Swinnen's (73) econometric analysis of farms in the former East Germany suggested that partnership-farms have higher technical efficiency and lower labour costs than individual farms and larger cooperatives.

Several US studies consider what factors affect the productivity of doctors in partnerships. A study analysing the effects of the structure and culture of medical group practices on the amount of resources used to manage uncomplicated hypertension episodes of care for enrollees in a Minneapolis-St. Paul HMO during 1990 suggested that resource use for a well-defined episode of care varies much more than one would expect in this highly competitive managed care environment; the culture of the group practice

appears to be more important than organizational structure in determining resource use for the treatment of hypertension, but together the culture and structural variables only explain 8% of the variance in resource use, a smaller influence than might have been expected (268). US doctors' productivity increased with their experience, but the productivity gain was least in the most complex types of services. Female US doctors had lower productivity than male doctors but also worked fewer hours (223). Without attributing more specific causes than the whole complex of clinical governance policies between 1998 and 2001, Campbell et al. (269) found that access to services, chronic disease management and the quality of angina care had all improved, but not quality scores for mental health care, care of the elderly care and interpersonal care, whilst mean practice budgets rose 3.4% in real terms. Diabetes care was better in larger practices and in practices where staff reported better team climate, but access to care was better in small practices. Preventive care was worse in practices located in socio-economically deprived areas.

Cooper et al. (71) describe the example of a legal partnership which limited pay differentials and therefore individual workloads to guaranteed partners an improved work-life balance. Wallace's comparison (118) of commitment to work between employed and professional partner lawyers found that organisations' structural characteristics were generally not very important in explaining professional commitment. Nevertheless, structure in the sense of skill mix did matter. Lawyers working in non- professional organizations were less committed to their profession than lawyers working in organizations whose members were mainly professionals. In the accountancy profession, organisational commitment was found to have a strong relationship with auditors' perception of the meaningfulness of their jobs. Identifying with the tasks they perform was associated with their professional commitment (270). Davies (271) touches on professional engagement when discussing the trend away from a traditional feature of general practice in the English NHS: a professional partnership routinely based on long-term relationships between doctors in the practice and between doctors and many of their patients. In arguing the NHS has adopted a shorter-term focus with salaried GPs likely to move between jobs more regularly, Davies suggests the service has become less stable. This trend may be reinforced by the decline in twenty-four hour care by GPs, with out-of-hours care often being provided by doctors the patient is not registered with (45). Scores for satisfaction, continuity of care, and access to care were higher in practices where staff reported better team climate (247).

5.4.2 Effects of incentives

Conrad et al. (223) examined the impact of financial incentives on doctor productivity in medical groups. They found that partnerships tended to have a governance structure where each partner served as both a principal and agent. Collectively, partners set their own fees (where permissible) and

agreed their own partnership constitution and reward structure. Individually, each partner made personal decisions based on the incentive structure and working arrangements offered by the partnership (272). In the large Canadian law firms studied by Greenwood, Hinings and Brown (103) partners built up a client portfolio which made them reluctant to move office in pursuit of 'career' or 'development'.

Several US studies evidence a connection between payments to individual doctors and their productivity (in the sense of volume of medical acts). Conrad et al. (223) explore the impact of financial incentives in medical groups, both at individual doctor and group level. Using secondary data from 1997 on individual doctor and group characteristics from two US-wide surveys, this study suggested that doctors in medical groups that base a higher share of the typical doctor's compensation on his or her own production are more productive (in terms of paid activity undertaken). Another study also showed that increasing the sensitivity of doctors' pay to personal incentives from 0% to 100% increased productivity by 28% (265). An earlier (1995) US national survey suggested that revenue sharing in a medical practices reduces doctors' effort compared with paying each doctor their own fees (FFS), whereas stronger (e.g. by +10%) links between pay and productivity correlated with increased office visits (patient episodes) (in that study, by +6.4%). Doctors' income was correlated with number of patient visits per week. Patient visits are twice as high in practices where doctors pay fully reflected their activity compared with those these it did not (101). These studies assume that incentives increase medical work-effort which raises visits per week which raises doctors' income. But (we note) these data are consistent with a simpler explanation: in the US health system, more patient visits generally raise the doctors' income irrespective of what causes the increased number of visits. An English study comparing implementation of mental health and CHD NSFs (183) suggested that incentives and guidance have a stronger impact on doctors' behaviour for care groups for which the doctor can single-handedly influence practice (i.e. clinically treatable physical conditions) than for those which require collaborative, 'social' treatment (e.g. mental health) which the doctor alone can influence less.

But if the demand for doctors' services is constrained, strong incentives for productivity become perverse. A large US survey (273) showed that if the demand for doctors' services is constrained, then the more closely doctors' income within the practice is linked to their productivity, the more doctors will compete on quality within their practices for patients, raising quality (in the sense of volume of treatments per patient) to what the author of that study regarded as an unnecessarily high level. Payment of a bonus, even one related to practice not individual productivity, appears to raise doctors' individual productivity. Equal distribution of practice income tended to increase (not reduce) US doctors' productivity, although the increase was less than with incentives for personal productivity. Incentives based on a capitation have a negative but small effect on productivity. Doctors in (US)

partnerships which own their own hospital appear more productive than doctors working in hospitals not owned by their partnership. Doctors in hospital-owned practices are less productive than those in independent practices However Conrad et al. (223) found ambivalent effects of not-for-profit status on doctors' individual productivity; the predicted negative effect was not found.

In England an intensifying policy emphasis on evidence-based practice and general practices' compliance with guidance such as NSFs and NICE guidelines were already producing improvements in the clinical quality of care before 2004 (274). The shift to the 2004 GMS tied around 20% of practice income to compliance with externally-defined quality standards. The result was high (91%) compliance with the (often increased) target levels of activity required of GPs (275). A comparison of two English with two Scottish general practices found that due to the new English contract patients experienced a more standardised, disease-oriented type of care with more tightly-organised recall systems. When QOF targets were relevant to it, treatment was liable to become more intense (245). Some of the additional workload was given to employed nurses (276), so these incentives accentuated the tendency for employed staff to increase faster than general practice partner numbers (249). Whilst some GPs (e.g. part-timers) could practically ignore the new contract, the 'lead' partners responsible for implementing it could not (38). A longitudinal study of 42 general practices showed the new contract's effects on quality of care to be complex. In the short term the new contract incentives appeared to accelerate improvements in quality for two (asthma, diabetes) but not a third (CHD) of the three chronic conditions studied. Once the contractual targets were satisfied the improvement in the quality of care for patients with these conditions slowed. Interpersonal aspects of care, and access to care, which were not incentivised were unaffected. Continuity of care (also not incentivised) deterioriated after the new contract was introduced (277). A longitudinal survey of English GPs found that overall job satisfaction, especially with pay (mean income rose from an estimated £73400 in 2004 to £92600 in 2005) and hours of work, increased. Against this, most GPs reported that the new contract decreased their professional autonomy whilst increasing their administrative and clinical workloads (278).

5.4.3 Employment status

A study to examine lawyers' sense of professionalism across solo practitioner offices and partnership, and status distinctions within law firms between associates, partners, and independent practitioners found solo practitioners and partners to be similar on most of the key dimensions of professionalism (autonomy, public service orientation, collegiality, variety of work). The greatest contrasts were between partners and associates within law firms. Partners and solo practitioners had similar experiences of autonomy and service-giving as owner-managers did, whereas partners and associates shared greater professional collegiality, perhaps fostered by law

firm cultures. All three groups reported comparable amounts of variety in their work and were equally committed to practising law. The key factors constraining professionalism arose from the nature of legal partnerships, in particular the time spent with corporate clients and pressure to generate profits. The everyday practical character of legal work in different organisational settings accentuated some, and diminished other, aspects of lawyers' professionalism. In that sense solo practice was not on balance 'more professional' than in a partnership (221).

Much published research has assumed that solo practice as the ideal professional work arrangement, and that when professionals become salaried employees their professionalism is seriously threatened. For doctors, the degree of 'enablement' (i.e. doing more skilled work) of doctors weakly predicts their commitment to their organisation. If enablement increases, a US study found, the transition from professional partner to employed doctor is compatible with the doctor maintaining or increasing her commitment to her organisation (87) even though the doctor has moved from independent to employed status. In England, analysis of census data on salaried GPs found slight but inconclusive evidence that their practices might have slightly higher QOF scores than other practices; and that salaried posts were attractive to doctors whose career stage or personal preferences made the role of practice partner unattractive or impractical for them (279). Overall job satisfaction levels were similar for salaried and partner GPs (280). A diary study (controlled before-and-after design) comparing ten standard GP partnerships with ten salaried GP practices found that the GPs in the salaried practices spent less time on practice administration but more working out-of-hours and in direct patient care, allowing more patients to be seen. List sizes per GP were higher in the salaried practices. Salaried GPs tended to provide shorter consultations compared than partner GPs, prescribe less often but not make fewer hospital referrals (281).

5.4.4 Cost-effectiveness

Although fee size may not necessarily be an indicator of cost-effectiveness, in a study of audit fees the bigger audit firms charged higher fees than smaller audit firms (282) and the larger client companies paid higher audit fees (283). However, the notion that the higher audit fees of the bigger audit firms reflects a higher quality service is supported by the work of Teoh and Wong (284) who found that the bigger audit firms produce more credible earnings reports. Indeed, the research of Read, Rama, and Raghunandan (285) suggests that small audit firms were ceasing some audits due to an environmental factor, namely the more stringent monitoring of audits in the USA following the collapse of Enron and Anderson. Similarly Dye (286) found that smaller audit firms generally earn less money and are more likely to leave the audit market. Nevertheless, the prospects of substandard audits increase as the length of time of the audit

and the client relationship increases or grows, and violation of professional standards become more likely with fixed fee audit contract (287).

Defelice and Bradford (266) explore whether solo or group practices in the United States are more efficient. Using a sample of 924 primary care doctors in solo and group practices, a stochastic frontier model analysis suggested that solo and group practice doctors operate at similar levels of efficiency; an important question for future research is whether the similarities in efficiency are due to the nature of medical practices or possibly the selection of doctors into the mode of practice that suits them best. Doctors are hired, managed and terminated only by their colleagues. Conrad et al. (228) argue that efficiency should not be defined as lowest unit cost per output, but instead as the greatest value-added (health benefit) for the least cost.

6 Systematic review findings: cooperatives and mutuals

6.1 Environment

6.1.1 Formation

A number of studies describe the formation of cooperatives as an attempt to increase market power. Two histories of US dairy cooperatives describe farmers' belief they could process cheese more cheaply than a private dairy monopsony (155); and farmers' attempts to countervail the supermarkets' power. Few commercial banks were willing to lend to US agricultural cooperatives so the latter founded their own not-for-profit bank (106). Credit unions in both developed and developing economies arose to remedy their members' exclusion from conventional banking services (288,78). In the USA, insurance mutuals arose as an efficient means of addressing the contracting challenges caused by aggregate uncertainties and moral hazard (289). As for rescue, the Kerala Dinesh Beedi cooperative was founded in response to a dispute between employer and workers about pay and conditions, a dispute which resulted in the original owners abandoning the enterprise and attempting to shift from employed to casualised sub-contracted labour (117). 'Rescue' was a common origin of western European producer cooperatives in the 1980s (96-99). Support for cooperatives is based on the belief that they provide a more satisfying environment for workers as they emphasise flexibility and cooperation (290).

Strong values or an ideology stimulated the formation many NHOs, for instance to correct ethnic or gender discrimination (98). Oerton (291,290) (indicates that women's experiences of discrimination in traditional organisational hierarchies encouraged some to look at alternative forms of governance that apparently offered more autonomy and control in the workplace, and less risk of the 'burn-out' due to more stressful ways of working in traditional workplaces. Some joined in reaction to gender discrimination in hierarchical organisations, including discrimination because of non-continuous and part-time career histories. Women mostly described their recruitment to the cooperatives as fortuitous. The Grameen Bank deliberately aimed to recruit women members, with the result that women are 94% of its borrowers (members) (292). Other cooperatives have originated to support economic development or from a religious motivation (293). A study of out-of-hours services cooperatives between 1996 and 1997 in the English NHS concluded that most GPs formed or joined cooperatives to reduce their hours on call to patients (45). Out-of-hours cooperatives reduced clinical workloads but also enhanced job satisfaction

and morale. For GPs instigated the formation of cooperatives (in Denmark and Ireland besides Britain) to improve their own working conditions (294). Turning to consumer cooperatives, a comparison of Group Health with nearby fee-for-service providers found the cooperative's patients to be somewhat younger than in the comparator system, come from larger families, have fewer pre-existing health conditions (59).

Charismatic entrepreneurs founded some cooperatives. Grameen Bank was founded by Muhammed Yunus, initially using his own borrowings as loans in an 'action research' project, financing self-help projects for poor, landless or illiterate people, especially rural women whose projects only money lenders would previously finance (at high rates of interest). Later this project was authorised as a bank (292). The Mondragon cooperatives were originated by one Jos'Maria Arizmendiarrieta (27), John Lewis Partnership and Raiffeisen by their eponymous founders.

Policy initiatives have also stimulated the formation of NHOs. Development of a suitable legal personality, land grants, educational and research facilities, and credit facilitated the growth of US agricultural, especially dairy, cooperatives in the 1930s. Similarly for provision of not-for-profit credit, managerial and technical advice in 1980s (106). Policy can also give unforeseen support to cooperatives. In English cooperatives, male cooperators were often able to supplement their income from the cooperative by taking state payments or benefits which were not available to the women members e.g. business enterprise payments (290). Wanyama, Develtere, and Pollet (78) outline how the foundation and subsequent development of agricultural cooperatives in a number of African countries stemmed from British, French, Belgian and Portuguese policies for colonial economic development. Unification of Germany led to the formation of new farm cooperatives from separate private farms (295). Consumer ownership of the Danish electricity supply system was established, then perpetuated, by legislation (105). Against this, in pursuit of marketisation policies the IMF, World Bank and US government forced national governments to remove the legal frameworks and budgets supporting many African and east European NHOs. In Yugoslavia the civil war physically destroyed many of the enterprises (122,78).

6.2 Structures

6.2.1 Modes of democracy

Two main modes of democratic control are described in the published research.

One is direct control, found in kibbutzim. A kibbutz rests on a founding principle of periodically (e.g. five-yearly) rotating managers out of their posts partly so that other members can experience the challenges of management, but also to prevent formation of a permanent hierarchy. Thus

kibbutz members are simultaneously the owners, managers and employees of their organisation (296). Between 30% to 50% of Kibbutz members participate in the controlling committees which run the enterprises. All members engage in running of the overall Kibbutz including enterprises which they do not personally work in. Workers deliberate proposals made by managers. General managers are elected. They select other managers, but the workforce ratify such decisions (297). In a study of small British cooperatives, women reported feeling more autonomous and influential in NHOs where men did not predominate (291) but meetings outside working hours made participation harder for women with children (290).

The other mode is federated representative democracy, found in larger organisations. Kerala Dinesh Beedi (KBD) cooperative had 35000 members working in 22 main plants. This cooperative used direct democracy within each department (typically 75-150 members) holding meetings every six months to discuss discipline and any apparent shirking by members. Each plant had an elected board of directors who usually served no more than a couple of terms and who were paid approximately the same as other members. These boards similarly elected a whole-cooperative board. The boards had powers of direction over foreman who in turn directed the supervisors who directed daily work, ensuring work discipline and product quality were maintained. The supervisors were thus accountable to a board elected by all the cooperative, so the workers whom they supervise could not alone depose their own supervisor:

That combination of democracy and delegation of authority seems to have been an essential element in KDB's success. (117), p.1451

This principle is also found in the John Lewis Partnership; top managers are elected but members do not elect their immediate supervisors.

The Mondragon cooperatives each have an elected board with the same powers as a corporate Board, but the Board may not include any employed managers or other non-members. A parallel elected Social Council represents the members in negotiations with the Board over pay and conditions, in lieu of trades union representation (298). The point of this arrangement is to give the Board and the Social Council clear-cut, unambiguous roles and interests (27). The main disciplinary mechanisms are written warnings, suspension without pay (up to 60 days) or expulsion from the cooperative if the member goes on strike (298). Mondragon Cooperatives also elect representatives (in numbers proportional to their membership) to a Congress which elects an executive committee, president and executive which have decision-making powers in the two years between each Congress (27). Caja Laboral, the cooperative bank created to finance all the Mondragon Cooperatives, is managed by bodies comprising equal numbers of CL workers and representatives of its parent federation of cooperatives (299), i.e. its users. The former Yugoslavian labour-managed firms gave the employees at each workplace usufruct rights over the firm's assets and residual earnings, and a vote in a worker's council which elected

managers (later, members gained the right to select managers by public competition), votes on production quotas, pay-rates and investment, but not the right to sell the firm's assets or their membership of it. They also had a system of tiers of indirectly elected representative bodies (122). The system was applied in the health sector.

As for consumer cooperatives, mergers of UK mutuals and co-ops gradually reduced the opportunity for members to serve on the Boards although fashions for ethical consumerism and fair trade tend to encourage support and participation. In a study of the largest UK retail cooperative a substantial minority (20%) of members said that cost of attending meetings influenced their ability to participate in Boards and similar bodies. Childcare commitments were a significant practical barrier to member participation. A geographically dispersed organisation incurs higher costs of these kinds. Links between coops and adult education (e.g. co-ops help fund adult education) contribute to the success of coops in Denmark, Switzerland 'and in the past in UK through WEA and similar organisations. Active members stated that the rewards of participating were not material but learning, contributing and expressing one's own views. To reinforce these benefits it is necessary to feed back to members the reasons for decisions besides the reasons themselves. Participating members do have a sense of community, but a weak sense of a very localised community. Local managers' capacity to interact with local members' groups and meetings is important to giving active members a sense of influence in the Co-op. Use of customer loyalty cards instead of dividend for members reduced consumers' incentives to join the Co-op and participate (174). Personal links to like-minded organisations made people more likely to join the UK retail Co-op. Face-to-face recruitment via shops is most effective recruitment method. Members' self-confidence encourages participation and vice-versa (89). The Eroski and Consum consumer cooperatives in Spain allow their employees to buy membership (including voting privileges) on the same basis as consumer members (300). The Danish electricity supply cooperatives have modified the one-customer-one-vote principle to allow larger customers the rights to send delegates with increased voting powers; 'one-kilowatt-one-vote' (105).

Size is a key issue for NHOs two reasons. Economies of scale are discussed below. Its other significance is for democracy; whether cooperatives and mutuals is whether they can continue to be genuinely member-owned and controlled businesses once they become very large (174). When first set up, cooperatives and mutuals tend to have small, simple organisational structures. Their decision-making structures emphasize maximum involvement by members through general meetings. This however becomes less straightforward as the mutual or cooperatives expand, diversify and become more complex in structure. As the number of members eligible to participate in democratic decision-making grows, Olson (301) suggests, the individual incentive not to contribute increases. There is also a dis-economies of scale in member coordination. Then, investor-ownership may provide better returns. In a large cooperative, members may feel it more

difficult for their actions to be decisive and for group identity to develop (174). However little evidence appears to be available showing the organisational size at which democratic control degenerates (296).

This raises the question of how NHOs renew their memberships. New members were recruited to the Kerala Dinesh Beedi cooperative competitively on the basis of a practical test of the skills required for their job. Gulati, Isaac, and Klein (117)attribute the longevity and success of the Kerala Dinesh Beedi cooperative partly to its recruitment of competent, ideologically supportive and non-corrupt managers. Wanyama, Develtere, and Pollet (78) describe the difficulties arising when managers of African cooperatives had the opposite characteristics. A new recruit to a Mondragon cooperative pays an entry fee (which can be deducted from subsequent wages) but she cannot sell her membership or this account to anyone else (27). US dairy cooperatives had the right to restrict membership but, at least until the 1980s, seldom did so (106). US agriculture cooperatives had a fixed membership subscription, making members who owned smaller farms less satisfied and more prone to switch cooperatives (68). As for consumer cooperatives, by entering a contract to buy electricity Danish electricity consumers automatically become members of the cooperative which supplies it (105). Most Grameen Bank borrowers (hence, members) are recruited by word-of-mouth, on bank reputation. Each new recruits must then recruit four or fives others, the number required to set up a new group (292). Many C19 and C20 American communes attracted too many intellectuals and too few practically useful workers. Their members often feared that the promise of material gain attracted recruits unwilling to undertake the hard work required for self-sufficiency (119).

In cooperatives as in partnerships mutual scrutiny was an important medium of control. In kibbutzim, workers scrutinise the work of new recruits. Control of workers is by reputation (which is highly valued). Non-compliant workers are likely to have their 'needs' for additional income regarded unfavourably, and to experience social isolation and eventual transfer away to another task (297). (Gulati, Isaac, and Klein (117) attribute the longevity and market success of the Kerala Dishesh Beedi cooperative partly to its workplace culture and members' ability mutually to monitor each other's productivity and work discipline. Grameen Bank members monitor one another's punctuality in repaying loans because non-repayment jeopardises future loans to others (i.e. themselves: two members of each group of five may receive a loan at one time). The same process applies to bank staff. The Bank's loan recovery rate was 99%, achieved partly by concertive control amongst back workers who publicly post recovery rates for each worker to see, so that workers pressurise each other to maintain the 99% rate (292). Members of therapeutic communities for drug users have therapeutic besides organisational reasons for mutual scrutiny (93).

6.2.2 Culture and ideology

Control of the work process in a kibbutz is provided partly through common values (297). Ronen suggests:

the main components of an individual's motivational set and job attitude depend largely on the system of social values with which he approaches the work environment and the organizational reward system. (302); p.85

Kibbutz workers were reported to place higher importance on intrinsic job facets whilst private sector workers placed higher importance on extrinsic job benefits (296). The same values-based motivation is reported in quite different settings (e.g. credit unions), although cooperative and 'entrepreneurial' (i.e. more corporate-like) cultures sometimes coexist uneasily (288). Strong ideologies can however be a mixed blessing for a cooperative or mutual. In the USA during the nineteenth century sectarian communes often succeeded in meeting their self-imposed aims because they in effect selected an ideologically-committed membership. The longest-lasting communes were Pietist and celibate. These early communes' sometimes odd rules about dress and conduct restricted free-riding because they deterred all recruits except those strongly committed to the communes' aims. Against this, doctrinal differences (for instance between socialists and anarchists about the desirability of post-capitalist hierarchies) tended to promote splits and failures, which about a third of the communes experienced. Originating in an ideological split tended to reduce a commune's prospects for survival, whilst originating as a spin-off from an established commune (with no ideological differences) tended to increase it (119). In contrast, the Grameen bank has an explicit set of political values, for example against dowry, but does not make (say) dowry-taking an obstacle to receiving loans and so becoming a Bank member (292).

6.2.3 Structural 'degeneration'

If the organisational structure of a cooperative, mutual or similar organisation does start to lose its non-hierarchical character that change occurs, existing research suggests, in three stages.

1. Democratic deficit: Côté (303) and Olsen (304) discuss the increasing difficulty of being a cooperative once its members no longer recognise the connection between identity of ownership and redistribution of surpluses based on their transactions. Then, Cote suggested, cooperatives will become emptied of organisational content, and the dominant paradigm of the investor-owned hierarchy will prevail. In default of member participation, managers take over governance. The UK Co-op's abolition of dividend payments to members in 1970s cut precisely this economic link between members and cooperatives: a 'fatal mistake' ((89); p.491) because it made the Co-op barely distinguishable from the corporations from whom the idea was copied. About 70% of UK building societies demutualised after 1984, mainly due to

managerial pressure and managerial opposition preserved the other 30%. That managerial preference could decide such a fundamental issue suggests a substantial 'democratic deficit'. Against this, it has been argued that mass participation is not necessary to ensure the smooth running of a large-scale cooperative. Members often feel apathetic towards voting and often choose to rely on a few core members to act on their behalf, rather than vote personally (305). Birchall and Simmons (174)segment consumer cooperatives' membership into three segments: 'true believers', who may include potential board members; a 'supporters club' who believe in the aims of the organisation and offer individual support through voting and attending social events; and those who vaguely support the organisation's values but do not engage much with organisational structures.

2. Expenditure on its services will, for many members of a consumer cooperative, be only a small fraction of their income. In the (large) Danish electricity supply cooperatives, most members act only as consumers not owners. Diversification of membership and their interests, besides an increase in cooperative size, has distanced Danish consumers from the electricity supply cooperatives that they are members of (105). Chaddad and Cook (170) describe how the ownership of US savings and loan mutuals was dispersed, regulatory and insurance systems insulated members from the effects of managerial decision, and so the management gradually became a barely-controlled self-perpetuating oligarchy. Regulatory changes to facilitate conversion and background changes in the financial markets, meant that about 90% of US savings and loan mutuals demutualised.
3. In many African countries, and Peru, democratic deficits arose as cooperatives became increasingly subject to control by public authorities rather than their members (78).
4. Hybridisation: Perrow (63) points out that increasingly, hired labour is being used in kibbutzim, embracing what Kibbutz founders regarded as the exploitative wage-labour structures found in corporations, with managers increasingly appropriating profits for distribution to external shareholders and treating departments and activities as profit centres. Managers cite 'commercial confidentiality' to justify withholding information from members about kibbutz work and finances (156,306). Similar events occurred in the Estonian cooperatives (152). To prevent formation of such an oligarchy, Irish credit unions only allow unpaid volunteers to be directors (288). Mondragon cooperatives have three categories of participant: members; employees; and temporary participants of either category. Reports of the composition of the Mondragon cooperatives appearing to reflect an increasing hybridisation. In 1995 that only 10% of workers were employees not members (27) but in 1999 that 30% were (300) and in 2003, 40% (299). Acquisitions may be at least part of the explanation. When the

cooperative took over two small foundries the workers there voted to stay employees not become members and the cooperative subsequently acquired overseas corporations as subsidiaries. In contrast, Kerala Dinesh Bedi remains exclusively a full-membership cooperative.

5. Demutualisation: Drake and Llewellyn (166) say growth is a strong argument for demutualisation; the typical mutual Building Society is simply too big to run democratically. Besides showing the effect of changing from a non-hierarchical to a corporate organisational structure, studies of demutualisation also reveal the ways in which NHOs may be susceptible to weaknesses of organisational structure. Chaddad and Cook's non-systematic review of demutualisations in the US financial sector identified relaxation of managerial and constraints as the main motive for demutualisation, but also point out that these studies did not examine the hypotheses that demutualisations were also motivated by the prospect of private benefits for members or managers. Hence, 'this hypothesis cannot be ruled out' ((170); p.586) (and was certainly not ruled out by informants in our building society case study).

We found a few exceptions to the above pattern. Cameron and Collins (307) (contend that some traditional rock bands of typically 3-5 musicians can be considered as worker cooperatives whose instability, due in part to lack of well-defined property rights and appropriate governance structures, can be reduced by shifting to a 'boss and workers' wage system. Individuals appeared to quit when their expected utility ((income) outside the band exceeded that inside it. In rather different cultural vein, a commitment to celibacy means that religiously-motivated communes eventually die out if they cannot or will not recruit new members from outside (119). Many nineteenth-century US communes died out with their founders because existing members suspected the motives of young people joining established, relatively wealthy communes. The Shakers attenuated this problem by hiring labour. Communes which allowed some personal property lasted longer than those which did not. Anarchistic decision-making (relational democracy) tended to prolong the survival of the commune but Thies (119) found only small numbers of such cases. Early agricultural cooperatives in the US were often funded by the issue of stocks, which over time became concentrated in fewer and fewer hands so that the cooperative where this occurred increasingly approximated to a shareholder-controlled firm (106).

6.3 Process

We found considerable diversity of working practices. Kibbutz factory workers have permanent roles. They define their own technical roles, divisions of labour and deployment. Ad hoc they can swap or adjust their shifts and rotas (297). Ezzamel and Willmott (201) incidentally describe similar arrangements springing up spontaneously in a weakly-managed

corporate factory. In contrast the Mondragon cooperatives, operating a diverse group of industries, agricultural production, housing, shops, educational centres, social security, consumer cooperatives, a bank and a research and development organisation (96) appear to have a relatively stable division of labour and allocation of work duties (298,27,300). A survey comparing matched samples of Italian cooperatives and corporations found that the cooperatives had more labour-intensive production methods than the private firms (308). A wider, more recent study of Italian cooperatives using 1991 census data showed that worker co-operatives emerged mainly in cleaning and security services, and road transport of goods, where employees' tasks are standardized and homogeneous, relatively little capital is required and the equipment is not firm-specific, in contrast to say mining and manufacturing where high investment is required and investments are firm-specific. Hence co-operatives mainly arose in food and drink manufacturing and wholesale distribution. Non-profit organisations (including but not limited to cooperatives) were concentrated in education and welfare services, where there is information asymmetry between customers and producers (309). Newly-recruited Grameen Bank members form a group to undertake loan transactions, receive training from bank worker, recite '16 principles' (No dowry, use pit latrines etc.). Because of customs of purdah many of the Grameen Bank's income-generating activities allow women to stay close to their homes (e.g., paddy husking and processing, sewing, cloth spinning, poultry raising, etc.). Besides their directly financial activities, Grameen Bank workers also provide education and training in family planning, personal hygiene, public sanitation, nutrition, and child development; and PE. Grameen officials are often deputed to work on outside projects (e.g. Grameen Krishi (agricultural) Foundation, Joyshagor (sea of joy) Fish Farm) to avoid a promotion logjam due to the pyramidal structure of the organization. These projects helped Grameen Bank recover most of its operating costs (292).

A (low doctor-patient ratio of about 1:1000 was found in the Group Health cooperative compared with about 1:481 for the equivalent fee-for-services alternatives. The performance of Group Health doctors was more uniform than in the comparator organisations and less sensitive to differences in doctors' qualifications. Group Health however found it less easy to adapt to changes in demand levels. Shortell et al. (59) concluded that different organisational forms appear differently to mediate the effects of differences in doctor and in patient characteristics.

6.3.1 Size and economies of scale

NHOs tend to be smaller than their corporate counterparts. In Oerton's purposive sample of UK cooperatives (not seeking small cooperatives alone) 39 out of 45 had 10 workers or fewer (290). A number of empirical studies suggest that US agricultural cooperatives tend to be smaller than the corresponding corporations, so that the former could become more technically efficient by expanding production so as better to exploit

economies of scale (68) but Craig and Pencavel's census (310) of US plywood cooperatives found no evidence of a negatively-sloping supply curve. Another study of US dairy producers showed corporations to be slightly more price-efficient than cooperatives, slightly larger than cooperatives and hence exploiting economies of scale more fully. Non-cooperatives showed about 20% more managerial (i.e. technical) efficiency than cooperatives. Porter and Scully (155) therefore concluded that due to its collective decision-making and property rights a cooperative is about 75% as efficient as a corporate counterpart. However, presence of cooperatives may prevent monopsony firms from reducing prices (to farmers) below a certain threshold. The effects of economies of scale can also work the other way. Cooperative farms in the former East Germany appeared more efficient than smaller organisations such as family farms (73). Some US retail cooperatives achieve economies of scale by operating a 'pre-order' system with one cooperative or branch collating individual or local orders into one large order to suppliers. This also allows economies of scale in (e.g.) warehousing (example given of Federation of Ohio River Cooperatives) (106). Jones and Backus (197) compared output, size, investment and factor proportions for four producer cooperatives with corporations in the British footwear industry from 1945 to the mid-1970s, finding that the cooperatives invested less, had smaller and slower-growing 'value added' (nett income). Jefferis and Thomas (98) argued that this was why (British clothing and printing) cooperatives found it hard to raise capital (see below).

Research on credit unions gives conflicting evidence about the effects of merger and growth. An econometric analysis of the growth performance of US credit unions during 1992-2001 investigated the relationships between size, age and growth. Ceteris paribus, larger credit unions grew faster than smaller ones. State credit unions grew faster than federal credit unions, and single bond credit unions grew faster than multiple bond credit unions. These patterns are attributed to variations in legislation and regulatory treatment. There is some evidence that younger credit unions tended to outgrow older ones. This seems consistent with a life cycle typology of credit union growth and development. There is also evidence of a positive persistence of growth effect. However another study found that the cross-sectional variance of growth is inversely related to size but (largely independent of age (311). The, increasing difficulty for the Portuguese Agricultural Credit Cooperatives (ACCs) in gathering equity since the 1990s forced many of them to merge. The incorporating ACCs were the more profitable ones with better credit management; the ACCs which they absorbed were smaller, facing difficulties in reaching a minimum efficient scale. They had weaker credit management and leverage problems. However the merged ACCs had heavy administrative costs and still faced profitability problems. The mergers had no positive influence on cost reduction, credit management and solvency ratio (312) (cp. also (313)).

6.3.2 Capitalisation

As time passes, the scale of technically-required start-up funding increases for cooperatives as it does for corporations. Contrary to some predictions, a survey comparing matched samples of north Italian cooperatives and corporations found no significant differences between them in terms of investment horizons or criteria for finance (308). Uvalic (169) cites similar evidence about Yugoslav cooperatives. US cooperatives' share prices appeared to be undervalued, a possible explanation of the difficulties which cooperatives have in raising capital from private sources (310,314). Easier access to capital was a strong motive for US savings and loans mutuals to demutualise (170). Yet indebtedness to external non-member (rentier) financiers or shareholders poses a challenge to democratic control. Early agricultural cooperatives in the US were often funded by the issue of stocks, which over time became concentrated in fewer and fewer hands so that the cooperative where this occurred increasingly approximated to a conventional shareholder-controlled firm. Even the cooperative banks founded by US dairy cooperatives imposed managerial and technical efficiency conditions upon the dairy cooperatives as a condition for lending to them (106).

When acquiring a private firm, the Mondragon cooperatives therefore acquire 100% so as to leave non-member shareholders no claims (27). US cooperatives can, under restrictive legal conditions, buy out older members' shares and retain them for use by future members of the cooperative (155). When indebtedness forced some early cooperatives to issue stock to the public, to prevent concentration of control they issued non-voting stock and limited voting stock ownership to one share per member (106). Having made a start-up loan and obtained two non-voting places on the Kerala Dinesh Beedi cooperative board the government did not further interfere in its operation, unlike public authorities' approach elsewhere in India, and had strong political motives for wanting the cooperative to succeed (117).

6.3.3 Marketing

Kibbutzim in many cases sell industrial products into the open market (297)and therefore undertakes conventional product marketing (with marketing mix). In contrast, the Kerala Dinesh Beedi cooperative sustained its sales with almost no marketing and sales promotion over a long period, relying on word-of-mouth recommendation and producing a higher product quality than its competitors (117).

Besides the dislike which businesses normally have for competitors, cooperatives have tended to arouse more ideological opposition because they challenge by example corporate business models and property rights. For example external firms (shippers) opposed the agricultural cooperatives in the USA and made it difficult for them to obtain favourable input costs (106). Co-operatives have at times also aroused ideological opposition from other sources. Some Islamic leaders tried to persuade borrowers (mainly

women, as noted above) and staff to leave Grameen on the grounds that use of a bank is anti-Islamic. The Bank therefore persuaded local Imans to say that bank membership is compatible with Islam (292). After the wave of failures in the commercial banking sector in 2007-9, the UK building societies which survived attempts at demutualisation have begun to 'Talk up' the idea of mutuality, emphasising the benefits of no shareholders, who seek to take the surplus away from the organisation (89).

6.4 Outcomes

6.4.1 Organisational survival

Various studies (see above) report, and others predict, NHO degeneration and demise but others describe NHOs which have survived long periods, a precondition for achieving any other outcomes. A study of British clothing and printing cooperatives suggests lower survival rates than corporations during the first five years (98), but not necessarily afterwards.

A study of 11 African countries showed that cooperatives there have withstood market forces and marketisation of the economy, and continued to grow in number and membership with a shift towards 'social economy' models (cooperatives collaborate with other types of economic institution and diversify their activities) from the 'unified' model (vertically-integrated federated cooperatives). Removal of state support and managerial linkages in the 1990s meant that the least well managed cooperatives collapsed but the survivors diversified and there was a nett growth of cooperatives (78). The Mondragon cooperatives have operated successfully and on a large scale since 1954, being now the sixth largest industrial organisation in Spain (299), manufacturing 'white goods' among other items. A survey of French producer co-operatives during 1970-79 found a high rate of survival with many of them over 50 years old with no evidence of degeneration in terms of the proportion of hired workers, productivity, profitability, or capital intensity. However the cooperatives' financial structures become increasingly inefficient with age due to over-accumulation of collectively owned assets and, in Estrin and Jones' view, under-utilization of external debt (315). The oldest Kibbutzim have survived, with the vicissitudes described above, since the late 1940s (156,297). The Kerala Dinesh Beedi cooperative has functioned successfully since 1965. The German Raiffeisen food cooperatives date from 1869, having maintained turnover size since the 1990s but reduced in number through mergers (295). The John Lewis Partnership (and latterly Waitrose) in the UK have developed a substantial market share since their nineteenth-century origins. Among consumer cooperatives, UK retail cooperatives and building societies have continued to survive and grow (largely but not only by merger) since the middle nineteenth century, experiencing various economic vicissitudes in doing so, of which the most serious was the demutualisation of the most building societies in the 1990s.

The above cases among others have survived competition from corporations, in many cases out-competing the latter if market share and growth of exports be any indication (27,300).

6.4.2 Livelihoods for members

To get cooperatives started members are often willing to undergo a 'shoestring' period of low pay (308,98). Afterwards the pattern changes. The Kerala Dishesh Beedi cigarette cooperative in South India dating from 1965 payed wages and benefits that (including 'fringe benefits' in kind) are around three times higher than those paid by its competitors, while at the same time providing better working conditions. Each member had to meet a standard minimum productivity target in order to qualify for the payment of needs-based supplements to the basic wage. The members were satisfied with this remuneration without attempting to maximise their income to the last rupee (117). Oerton examined male workers in social enterprises, finding that these men cited the benefits of being able to enjoy some of the conditions traditionally associated with women's work 'namely having more routine, less-pressurised, less competitive working lives. But women members' income from the cooperative was generally lower than men's, even allowing for women's greater tendency to work part-time and women had less security of tenure (290). The presence of dairy cooperatives in the USA may have prevented corporations reducing prices (to farmers) below a certain threshold (155). Often Kibbutz members are paid well in excess of the accepted rates for the work they undertake (296). Kibbutzim originally functioned without waged labour, distributing operating surpluses equally with an adjustment for needs (297). The Israeli Registrar of Cooperatives stipulates that any which implement differential wages lose Kibbutz status. In UK cooperatives, maternity provision was generally more generous than the legal requirements and ordinary employers' provision. Mondragon cooperatives retained between 30% and 50% of operating surplus for reserve funds and redistributed the rest according to members' hours worked and pay grade. A percentage also went into each member's account (based on her entry fee), from which interest was paid back to the member (298). This reserve fund tides the cooperatives over market fluctuations of income. During the economic recession of the early 1980s, the cooperatives reallocated members and other resources between each other in order to retain full employment (27) and tended to vary wages rather than numbers of employees (298). A survey of plywood producers in one US state also found cooperatives were more likely to adjust wages and less likely to reduce staffing in response to market changes than corporations were (310). However the benefit to members (rather than 'society') has also been cited (316) as a reason against including doctors on the boards of not-for-profit hospitals, implying a trade-off between the policy objectives of social benefit and professional engagement in the running of not-for-profit hospitals generally. Towards the end of their existence some Yugoslav cooperatives were raising wages at the expense of investment (122).

Describing 30 early mutualisations of US life insurers (formerly shareholder-owned) Mayers and Smith (317) found that the rate of growth of premium income from policyholders remained unchanged, stockholders received a premium for their stock and management turnover declined. They conclude that mutualisation was 'on average efficiency-enhancing'.

Effective, honest, and dedicated managers appear to contributed to the success of the Kerala Dishesh Beedi cooperative. A few professional managers were recruited, but their proportion and pay was lower than in the commercial sector (at perhaps one tenth the level in Indian corporations). These managers were subordinate to the elected board at whole-cooperative level (117). Wage differentials in the Mondragon cooperatives were in the order of 4.5:1 and in industrial kibbutzim 3.5:1 (306). Kibbutz managers were paid about half the pay of their private-sector equivalents (298). For perspective, the differential between the highest-paid company director in the UK (£36.8m per year (Guardian, 14th September 2009)) and the national minimum wage is over 3000:1.

6.4.3 Quality of working life

A study comparing workers' job satisfaction in the profit and non-profit sectors of seven European countries showed the workers in the non-profit sector had greater job satisfaction, attributed to the workers' greater autonomy at work and their greater satisfaction with the type of work they were doing. These workers therefore developed a stronger intrinsic motivation to carry out their work (318) ('non-profit' includes but is not limited to NHOs). The same was reported, and a propensity to monitor each other's work, at the Kerala Dinesh Beedi cooperative (117). Workers of both sexes found that cooperatives enabled a more flexible accommodation of private and working life than the conditions given by hierarchical employers (290).

6.4.4 Cost-effectiveness

A meta-analysis of productivity data from 43 surveys covering a number of countries concluded that on balance labour productivity was higher in one-person-one-vote producers than comparable corporations (seven surveys versus two, and two equivocal surveys: none stated which findings were statistically significant). Profit-sharing was associated with higher productivity (all surveys), and more strongly association than worker ownership was. On balance (two statistically significant surveys versus one) worker ownership was nonetheless associated with higher productivity (319). A survey comparing matched samples of Italian cooperatives and corporations found the cooperatives had higher productivity, lower income differentials, and fewer industrial disputes (308). A now rather dated econometric study estimated that whilst the productivity effects of various forms of worker participation in producer cooperatives varied between settings, the overall effect was positive, most uniformly with respect to

profit sharing and, somewhat less, individual share ownership and participation in decision-making. Collective capital ownership had an insignificant or a negative productivity effect (320). Low administrative costs were not related to other aspects of partnership and NHO performance (321). The Kibbutz movement as a whole had large debts following Israeli financial crises in 1980s due to high-interest loans promoted by government, market collapses and banking irregularities. From mid 1990s Kibbutz growth rates for exports and overall sales exceeded private sector's (297). Before the effects of the (external) oil crises were felt in the late 1970s the Yugoslav cooperatives were sustaining average growth rates of 7.2% annually (122). In Estonia, however, worker-owned firms were not more productive than corporations because the former were often reluctant cooperatives to start with, being worker-owned but not worker-controlled (instead, bureaucratically managed) (152). French cooperative banks have survived by specialising and diversifying in providing credit. Their market role increased during the 1990s. They maintained higher profitability than the commercial banks during 1992-1999 and similar profitability in the period thereafter. Because they cannot be taken over by commercial banks they retain a capacity to influence the development of financial regulations in Europe and globally (322). UK building societies started to outperform commercial lenders on interest and market share from c.2001; and were more trusted than investor-owned banks (89). Three studies of US mutuals (323-325) showed that those which demutualised showed increased (but also more variable (326)) profitability and share price, and faster growth, linked in Cole and Mehran's (323) view to the stronger financial incentives on managers who became shareholders and according to Cordell, MacDonald, and Wohar (327) and to Esty (326), linked to a switch of investments towards higher-growth, higher- risk financial instruments. This increased financial performance is the foundation of the agency-theorists' claims that de-mutualisation increases 'efficiency' (in the micro-economic not the technical sense). However,

In general the literature is silent about distributional effects related to demutualisation, particularly the effects on depositors following demutualisation. (170); p.581

Although demutualisation does appear to provide members with access to 'unallocated equity and reserves' (ibid. p588). (The 2007 financial sector crash however cast considerable doubt on some of these claims. To the extent that they did not imitate corporate financial management practices, mutuals weathered the crisis more successfully than corporate financial institutions. Indeed it was failures of the latter, not of the mutuals, which triggered the crisis (328).

In the health sector, van Uden et al. (329) found that it made no difference to the costs of running a cooperative whether it was integrated or not with a hospital A&E department, although the integrated cooperative had greater impact on reducing A&E admissions. But reducing the number of patients seen produced dis-economies of scale, hence higher costs per patient.

6.4.5 Values

Cooperative organisations are still viewed as 'alternative'or marginal organisational forms. Regarding gender issues in social enterprises, Oerton (concludes that women workers in cooperatives and collectives have a greater tendency towards being exploited by virtue of being women rather than being simply workers in a cooperative or collective, a tendency underpinned by familial and gender specific 'orientations' ((290); p.218). Her research indicated that women workers in social enterprises are usually materially disadvantaged when compared to their male counterparts, receiving on average lower earnings, even allowing for that fact that the women were mostly employed part-time. However, the women had different expectations from their male colleagues about what constituted 'well paid' They were more likely to view their jobs as temporary and hence make plans to move in and out of employment in response to personal or family needs. Despite children being undifferentiated by sex (clothing aside) in their early years, by 1975 the sexual division of labour in the Kibbutz had reached an 80% saturation of women in education and consumption (laundry and food production) and men in production. Simons and Ingram (296) suggest that Kibbutzim fail to maintain social equality because sex-role differentiation is too engrained in society at large, indeed in basic human motives, for the Kibbutzim to abolish.

6.4.6 Quality of product or service

Kerala Dinesh Beedi cooperative survived for many years by producing a higher-quality, higher-priced beedi than its commercial competitors (this is what enables it to pay the high wages mentioned below) (117). Hanf (295) (notes how some of the Raiffeisen cooperatives are forming centralised networks with closed membership in order to impose higher standards of quality control on the goods their farmer-members supply. Sloan et al. (330) reported that for US hospital admissions of 91 days or less duration for four acute conditions (primary diagnoses of hip fracture, stroke, coronary heart disease, or congestive heart failure) between 1983 and 1995, costs were higher in for-profit than government and non-profit hospitals (including but not limited to NHOs). There was no significant difference in survival, changes in functional and cognitive status, and living arrangements. Shortell et al. (331) compared semi-affiliated hospitals with their market area competitors (550 system hospitals and 555 of comparator hospitals). Not for profit system hospitals provided a wider range of services than investor owned systems hospitals, a higher percentage of services for which charity care was offered, and were more likely to provide unprofitable services than not-for-profit system hospitals. Both corporate and not-for-profit hospitals offered wider ranges of services under highly competitive conditions. These findings concern not-for-profit hospitals generally. A more focused though now rather dated US study showed that patients at FFS services reported higher satisfaction than at a cooperative (Group Health). Nevertheless, Group Health met a higher proportion of indicators for high

quality care than fee-for-service (FFS) providers did. Its patients had greater continuity of care than FFS patients, except for Group Health patients seen by 'internists' (generalist physicians treating adults) but this difference had no impact on the main outcome indicator (age-adjusted blood pressure). Care group characteristics seem to influence successful (in terms of main outcome indicator I.e. age-adjusted blood pressure) care delivery in Group Health-like contexts, provider characteristics seem more influential in FFS settings. No relationship was found between doctor performance and the main outcome indicator (age-adjusted blood pressure). The linkage between access and perceived satisfaction was stronger among Group Health patients than among patients of the FFS comparator (59).

European studies give divergent conclusions about patient satisfaction with primary health services provided by cooperatives. Hallam and Henthorne's case studies of primary care cooperatives' emergency centres found that patients attending the centres were as satisfied with their treatment as those patients visited at home, and more satisfied with response times (45). McKinley et al. (332) however found that patients seen by deputising doctors (including by implication those from co-operatives) were less satisfied with the care they received than were those seen by practice doctors. The greatest difference in satisfaction concerned delays in visiting. There were no differences in the change in health or overall health status measured 24 to 120 hours after the out of hours call or subsequent use of the health service in the two groups. Another counter-example was an Israeli experiment in the form of fertility clinics that used lay clients as co-producers of a professional service (333). Involving clients as co-producers in service provision lowered the satisfaction of clients and staff with work and services. A study (294) of one Irish OOH cooperative found generally high levels of patient satisfaction but patients with lower physical and mental health status scores were less likely to be satisfied, as were patients with higher socio-economic status. Age, gender, and call outcome did not significantly affect overall patient satisfaction.

7 Bibliometric profile of the reviewed literature

The number of relevant theoretical studies was higher than expected, the largest single category being a priori economic models rather than organisational theory. We have already noted how ambiguous terminology in this area of research is. Oerton's comment (291) that the literature on NHOs focuses mainly on class relations (taken to include property rights) rather than the effects of NHOs on gender (or indeed other forms of) inequality remains true.

Our electronic search found 71 relevant empirical papers about cooperatives and mutuals, and 122 about professional partnerships. The former tended to concentrate on a few celebrated cases (e.g. Mondragon, US agricultural cooperatives). Many studies which might otherwise have been informative failed to differentiate egalitarian and democratic organisations from hierarchical not-for-profit organisations. Table 5 shows the distribution by geographical region from which the data (as opposed to the authors) came.

Table 5. Distribution of papers by region of origin of data

	NHOs	**Partnerships**
UK	9	28
Rest of Europe	7	21
Australia and New Zealand	1	3
Canada	2	10
Israel	4	1
USA	25	51
Elsewhere	8	0
Two or more of the above regions	3	4

We give data separately for Israel because of studies of kibbutzim are prominent in the research literature on cooperatives and mutuals. Not included in the databases we searched was (a more extensive literature (including a specialist journal) about kibbutzim, including literature in

languages other than English. Table 6 shows the distribution by economic sector.

Table 6. Distribution of papers by economic sector

	NHOs	Partnerships
Accountancy	0	22
Agriculture	9	2
Architects	0	2
Consultancy	0	11
Finance	3	0
Health	12	57
Law	5	28
Manufacturing, building and retail	15	0
Women's organisations	4	0
Others	11	3
Two or more of the above	0	4

'Finance' includes banks, building societies and credit unions. 'Others' included veterinary services, museums, social clubs, music groups, unspecified 'voluntary organisations' and a radio station. Two now rather dated studies report forms of professional partnerships in health care which had not been formally evaluated at the time nor, so far as we could discover, since: partnerships which combined general physician and rheumatologists (i.e. partners working in primary and in secondary care) (334); and a medical partnership based on hospital premises, making use of the ancillary services in its host site (335). Many more papers reported producer than consumer cooperatives.

Across the thematic components of the ESPO framework outlined above, papers were distributed as Tables 7 and 8 show.

Table 7. Distribution of papers by ESPO category

	NHOs	Partnerships
Environment	34	83
Structure	54	80
Process	38	75
Outcome	51	40

Table 8. Distribution of papers by ESPO relationship

	NHOs	Partnerships
Environment - Structure	28	41
Environment – Process	8	19
Environment - Outcome	13	6
Structure - Process	39	23
Structure - Outcome	25	16
Process - Outcome	28	11

Generally the outcomes studied were more often financial and market outcomes (growth, market share, competitiveness) or organisational (e.g. membership numbers, longevity of organisation) than 'real-side' outcomes. The statement (308) that the empirical literature contains many diverse, often conflicting conclusions remains true. In general, the systematic review findings are impoverished by the difficulty that the most abundant, and often high quality, studies from the USA seldom empirically differentiate partnerships, NHOs and other organisational structures.

Methodologically the distribution of research designs was as Table 9 shows.

Table 9. Study designs

	NHOs	Partnerships
RCT	0	1
Quasi-experiment (non-randomised controlled)	0	0
Longitudinal, multiple cases	6	25
Cross-sectional or comparative	26	66
Single case study	20	21
Laboratory game, simulation or experiment	3	0
Other	3	5

'Cross sectional' and 'comparative' are grouped together as the respective designs in quantitative and qualitative methodologies for making observational comparisons. 'Longitudinal' also covers both quantitative designs (e.g. time series) and their qualitative equivalent (narrative histories, including recent histories). In terms of hierarchies of evidence (336) the research appears to be concentrated in less-than-gold-standard designs but experimental studies are generally rare in organisational and policy research (though not unknown (337)). The number of cross-sectional studies of partnerships reflects the high proportion of surveys using US data-bases. Of these 31 were in the health sector and covered (but were not all limited to) medical partnerships. Of the 25 longitudinal studies of professional partnerships, 21 were narrative histories. The 'other' category contained no systematic and 6 (2+4) non-systematic reviews.

We also classified studies by the representativeness of their data in the descending hierarchy of sampling strategies shown in Table 10.

Table 10. Sampling strategies

	NHOs	Partnerships
Census	17	49
Randomised sample	2	6
Purposive sample	10	26
Convenience sample	1	7
Single case	18	21
Other	6	9

'Purposive' includes 'qualitative' or 'theoretically-driven' sampling. 'Other' includes studies where the sample was not clearly specified (e.g. just described as 'representative'). Although this table gives an overview of the literature studied its implicit ranking should be taken with caution. A single case-study (e.g. (338)) describing the history of a whole sub-sector of an economy for a long period might present more safely generalisable conclusions than a census of narrowly-defined organisations in a small region or idiosyncratic setting. The proportion of organisational censuses again reflects the number of studies which re-analyse US databases.

8 Environment: case study findings

We present our primary empirical findings in research question order, which matches the order of the main headings in our research framework. (This chapter begins by summarising the empirical patterns found in the case studies about the relationships between the study organisations and their environment.

8.1 Organisational goals

Goals of the study organisations related mainly to:

1. Personal work interests of founder-members or partners
2. Values or ideology
3. Finance
4. A particular locality
5. Quality of working life

These five were present across all the study sites although the relative prominence, and of course content, of each varied.

8.1.1 Personal work interests

In the professional partnerships, the organisation was a vehicle for the founding partners' personal work interests, which the organisation's de facto goals included. Thus in PharmPlus practice areas of special interest (dermatology, ophthalmology) developed simply because that was what the individual GPs were interested in. For the pharmacist,

for me this role [partner] is better [than salaried or subcontracted pharmacist] because I like to create things and I like to shape ideas and to be at the heart, at the top, with the partners, driving the process, it's what makes me tick.

(Pharmacist Partner, PharmPlus)

At PlusPM one manager-partner had an interest in target-meeting so this figured prominently in practice goals. Another partner had interest in making PlusPM a training practice. However formation due to visionary personal interest or motivation could also inhibit future recruitment of partners who, existing partners feared, might not be of like mind. Thus in NurseLed:

So the Board [of partners] is just the three of us 'we've talked a lot about expanding the Board but [name] and I have such a clear vision of what we want, and it's our baby, that we've been very hesitant.

(NP partner, NurseLed)

The organisational structure of PCTrun practice directly reflected partners' interests in another way. The GPs remaining after the senior partner retired

were uninterested in management and wanted to concentrate on clinical work. They became salaried GPs employed by the PCT to do the work they had as partners, choosing nationalisation because it served their personal work interests.

In professionally-controlled NHOs too, one goal was to realise the members' view of how services ought to be provided:

because it is owned by doctors, because although it's NHS and all that, the organisation is owned and run by doctors. And it's easier for the doctors to say what they want and do the out-of-hours how they want it.

(Finance Manager, City)

Personal development was another motivation for helping found, or joining, an NHO. Thus in Metro:

I got involved in the first place because one of my other jobs is as a GP tutor for [town], and I was very keen to start getting a protected time scheme for doctors developed so that they could have educational events in the daytime, and originally the PCT wasn't (prepared to fund these, and Metro was.

(Clinical governance lead, Metro)

Similarly the accountancy partnership used a generous personal development programme to help recruit good-quality staff in face of competition from the big four accountancy firms.

8.1.2 Principles, ideology, 'values'

Many of our informants were motivated in part by a set of principles or values, or an ideology.

Three of the cooperatives studied traced their origins to principled, visionary founders. Wholefood was founded by two individuals who in principle supported the idea of cooperatives and therefore acted as 'seedling' members, helping to establish one cooperative before moving on to help start another. Our large retail cooperative clearly traced its origins to its founder, who had inherited a department store from his father. Years later the founder explained his motivation to the BBC:

It was soon clear to me that my father's success had been due to his trying constantly to give very good value to people who wished to exchange their money for his merchandise but it also became clear to me that the business would have grown further and that my father's life would have been much happier if he had done the same for those who wished to exchange their work for his money ...[I came to] the notion that the relation of employers to employees should be that of lawyers or stockbrokers to their clients or of doctors to their patients or of teachers and trainers to their students. None of these experts ask for their services more than a definite fee quite moderate in relation to the importance of the service they give for it.

(BBC broadcast, 15th April 1957)

HouseLend could also trace its origins to a visionary founder, in this case one who had the idea of establishing a mutual building society which, unlike previous building societies, was permanent (not 'terminating' once its

members had built themselves housing) and which financed rather than built housing for its members.

Among the general practices we studied the goal most often expressed was that of providing a good quality of service:

To try and provide a good standard of health care within the resources that we are given, having an eye to ' we want to be cost effective with regards to ' it sounds awful but we are not a high prescribing or high referring practice because we feel that we should be referring and prescribing appropriately.

(GP, PlusPMs)

The health cooperatives also emphasised the goal of good quality care. The 'mission' of Metro was to:

Provide the highest quality, most efficient and appropriate out of hours care for our commissioned PCTs and their full patient population. We aim to be a central agency to develop the widest range of complementary primary care too. We see ourselves as part of the NHS, and therefore strive to act in the best interests of the wider NHS economy and community.

(finance director, Metro)

At City:

Everyone would demand, and even [City] would demand of itself, is that the patients are the ones in the centre of all this, so whatever we do we have to provide care to patients.

(Finance manager, City)

Its website presented its goals for the quality of its services, emphasising the values of 'respect, scientific discipline, integrity, pioneering spirit and stewardship'. Equivalent statements were made by informants in non-health cooperatives and mutuals. In the case of the small food retailing co-operative we were told, quite simply, that 'one of our mission statements is to cook some healthy food' (Member, Wholefood). Another aim was to create sustainable employment.

It was noticeable that quality of service was the goal most often mentioned, unprompted, across both the partnerships and NHOs.

In addition the cooperatives valued the idea of cooperation in itself; 'we want it to operate like a co-operative with the same ethos.

(MD, Metro). Formation of OOH cooperatives offered GPs a better way to discharge a responsibility which they felt towards their patients, but also the opportunity for GP members to recoup at least some of the cost of these services by working paid sessions for the cooperative. In the other cooperative:

In the entire country there was an entire revolution happening at that time, we all know that, right? Coincidentally [name] had a framework, or a legal framework, of a company limited by guarantee which was a co-operative, which was a social enterprise reason because it was not for profit.

(CEO, City)

In describing how they made decisions, our informants in the small food cooperative repeatedly mentioned their founding ethical goals. For that reason they had turned down a multi-million pound contract from one of the largest supermarkets in the world. However they did make large contracts with two other supermarkets (one commercial, one cooperative) whose policies they found less objectionable.

8.1.3 Finance

Consumer cooperatives were a partial exception to the above pattern. Members' motivation for joining changed over time. Many people joined the consumer cooperatives not primarily because they supported the notion of cooperation or mutualism but either on grounds of price (OverThere) or economic security (HouseLend). As the chair of the OverThere Senior Caucus stated,

99% of them look at one thing, price and I don't think there is anyone in the organisation who, if they were being 100% honest, wouldn't say the same thing.

This seemed to be unanimously agreed by members and staff alike when asked the question.

Otherwise, our health sector, co-operative and building society informants all stated that the relationship between financial and other goals was that remaining solvent was a precondition for meeting the other goals. Solvency was thus an instrumental, subordinate goal. At NurseLed:

the idea of a social enterprise is that we don't make a profit, we don't have shareholders who are staff, we put it back into the practice. 'at the end of the day this [practice] is a business and needs to be run as a business... [although] Financially we're not a particular success because we have high employment costs.

(NP partner, NurseLed)

Insofar as the partners of this practice were interested in profits, it was for the developments which they could then finance:

We provided a foot clinic right from the beginning, the free foot clinic, we pay a foot care specialist to come in and run a foot clinic 'we would do more of that sort of thing if we had the profits, but we don't. If we had the premises like Bromley by Bow we would have the art exhibition or a coffee shop would be great 'I've got an artist's impression here if we did ever move to our dream new practice. So then we could be a proper social enterprise, make a profit on the coffee shop, set up a mother and toddler group 'but we haven't got room here.

(NP Partner, NurseLed)

PharmPlus's goals expressly included the need to improve productivity to increase profitability so as to invest in staff and pay partners. Hence the pharmacist partner also expressed the aim of maximising profitability of the pharmacy (which generated about 60% of the practice surplus).

For the cooperatives too:

all the surplus, because we don't have a profit, all the surplus legally enters back into the cycle of development for the patients.

(CEO, City)

When City made an unplanned surplus, the members decided to invest the money in buying its own building. A leading member of the small retail cooperative implicitly differentiated profitability in the sense of earning a livelihood from members' own work from profiting from the labour of others (i.e. employees):

co-ops aren't necessarily a non-financial award [sic] organisations, [but] they're non-, I think you could say that they seek to be non-exploitative.

(Member, Wholefood)

This organisation too believed it was necessary to cover its costs and to develop, but that was not the same as maximising profits and therefore income:

I'm sure compared to some business manuals, we are not maximising our income generation, income generating potential as much as others, but that would have to be in line with what we individually and collectively feel comfortable with.

(Member, Wholefood)

For years the cooperative subsidised its loss-making cafe with profits from its shop. However the larger retail cooperative adopted as goals certain of the standard retailing outcomes are also adopted by corporations: cost control, costs as a percentage of sales, service levels and their achievement.

The 2007 financial sector collapse had especially sensitised the mutual building society which we studied to the goal of solvency. Its chief executive expressed it by saying that the society has a set of principles, but the clearly predominating aim in the current financial market was to remain solvent. Practically all HouseLend customers (members) were (we were told) aware that it also exists to make profits but these profits are re-invested in the society and not paid out as dividends to shareholders but return to customers as lower interest rates. HouseLend was interested in long-term profit making only in the sense that:

in the long term we do need to generate profits to have a sustainable model, to make sure that we can out-strip costs, inflation, to give development opportunities to staff because you don't shrink to greatness.

(CEO, HouseLend)

However, the Society could in principle chose, for the short term, not to grow or increase profits because:

we don't have to report to the City on a quarterly or six monthly basis that we are showing an increasing trend in doing so.

(CEO, HouseLend)

In explaining the main differences between the financial goals of mutuals and corporations, he concluded:

the whole issue of how much profit we should make and performance management for profit is worthless, except for a PLC.

(CEO, HouseLend)

The architectural partnership wanted to make a profit, but expressly not to become over-commercialised. They were also committed to the goals of working for the healthcare and the public sector as interesting and worthwhile activities in their own right. Intensified competition had however led them to a shift towards more performance-oriented goals and to pay closer attention to quality control, sales and marketing.

In all these cases the financial goal was to break even, including in the costs to be covered the members' guaranteed income, some development and improvement to existing services.

Nonetheless several of our study organisations had also set up a parallel for-profit company whose purpose was either to sidestep regulations limiting the range of activities they could undertake (i.e. pharmaceutical services, in PharmPlus general practice) or to provide a mechanism for returning to the members of a discontinued cooperative their initial subscriptions which had been spent largely on buildings.

In order to limit the risks to which its partners were exposed, the accounting partnership we studied had adopted the limited liability partnership structure. This was also a way of meeting transparency and governance requirements in their sector, and making recruitment to the partnership more attractive.

8.1.4 Locality

Both out-of-hours cooperatives which we studied had the goal of providing services for GPs and patients in their particular locality. They showed little interest in activities elsewhere. City's goals expressly included recruiting local doctors for local services;

No we don't look at those applications [from elsewhere in England and from Germany], we just say we can't, sorry, we don't, because we are local so we just take local [doctors].

(CEO, City)

Metro too was uninterested in bidding for work or recruiting members beyond its own conurbation (an area of about 25km radius). An exception to this localism was OverThere which, despite its origins and values, did not pay much attention to local ethnic minorities or other marginalised groups, and was prepared to acquire new partners and resources outside its original area of operation.

Localism was also a goal, though less pronounced, in the non-health cooperatives. In descending order of local orientation, the Wholefood cooperative supported local food production despite acknowledging that the geography and climate of its region were not especially favourable. The legal partnership that we studied had the goal of becoming the largest firm

of lawyers in the south west region specifically. It had originated there, where some of its founders (and other members of their family) were for over a century prominent political figures, and did not express any national ambitions. Although now operating all across the UK, traces of original ties to a particular locality also remained evident in the building society we studied. Like many mutuals its name reflected its place of origin where (after 150 years) its headquarters still stood and its AGMs were held. Its county of origin was still disproportionately represented among its branches.

The large retail cooperative was the exception to this pattern. It had branches all across the UK. All products were nationally sourced via the Head Office. There was some, but not much, regional or local variation in its product range. It regarded itself as a national organisation with no particular regional affiliation.

8.1.5 Quality of working life

Quality of working life was another goal recurrently mentioned, although our informants' idea of what constituted a satisfactory working life differed from site to site. For PCTrun, it was simply one that allowed GPs to do clinical and not managerial work. PharmPlus informants also mentioned home-work life balance although they saw that as a 'softer' (flexible, negotiable) goal. The practice manager had suggested that the number of partners or salaried doctors' hours could be cut if the partners were prepared to work more hours, but the partners decided against 'ending up being completely stressed out by the time they came to their holiday'.

The out-of-hours (OOH) cooperatives' goal was to meet their members' contractual obligation to provide out-of-hours cover. A motive for founding the cooperatives was originally simply to enable GPs to get more nights of unbroken sleep by setting up turn-taking systems for out-of-hours work. Indeed, Metro offered members the option of (paying a subscription and letting other members do all the work. These cooperatives were intended to replicate the partnership structure in another setting:

The concept started like a practice at night. The GPs had their practice at day, they said, "Why not have a practice at night?'so City initially was coined as a practice at night, and so it would have very similar features to a practice within the daytime, except that there would be moon instead of the sun.

(CEO, City)

Beneath the differences in rhetoric and self-descriptions, there was little difference in organisational structure and work processes between City and Metro.

8.2 Competitive strategy

Mostly the co-operatives' and general practices default strategy towards other co-ops was non-competition rather than a competitive strategy, still less predatory:

We have good working relationships with these other co-ops [in neighbouring PCTs]. Most of them are not-for-profit, so there is no financial reason to just grab everyone and make everybody go bust. .

(Finance Director, City)

At Metro too:

I still don't think we would become as predatory as to just tender against other local providers 'for what benefit? We're a non-profit making organisation.

(MD, Metro)

Indeed, its attitude towards potential rivals was the opposite of what one might have predicted for a corporation, for it still shared best practice, information and ideas even with a nearby cooperative that had teamed up with a commercial organisation and was tendering against other local cooperatives.

We found the same attitude in the smaller retail cooperative:

When we set up, we didn't set up to use our leverage to put other businesses out of business. If we set up a cafe, because we've got a captive customer base we would affect the trade of other shops around here, such as [name] Cafe's, [another name]'s which is just across the way there, and that's not what we intend to do; we're not here to become a giant ourselves.

(Member, Wholefood)

Informants in the large national retail cooperative were rather indifferent to its competitors. None of the respondents spoke of the national retail environment, only their own company environment and local civic issues. Nevertheless, this cooperative has a strong market presence and brand names which are as well known as the largest corporate supermarkets'.

In PlusPM and PharmPlus, the nearest equivalent to a competitive strategy was to consider whether to take over smaller nearby practices if the chance arose. NurseLed displayed a similar attitude. When asked about competitors, the salaried GPs at PCTrun mentioned no nearby practices but a walk-in centre at the city about 25km away.

OverThere had become increasingly exposed to competition, ironically of its own making in the sense that it had been a pioneer which demonstrated the feasibility of pre-paid OverTherecare cover for people of moderate income. This success prompted commercial insurers to compete. OverThere's response was to form an alliance with Kaiser Permanente, involving cross-over cover for each other's members (each organisation would treat the other's members at its own facilities) and the sharing of technical information about clinical practices but the two did not merge. Our accountancy partnership were well aware of other partnerships, especially

the 'Group A' firms as competitors, but also maintained dialogues with their main competitors, and decided that their were certain market segments where the partnership was just not interested in competing for custom. Informants in the legal partnership rarely mentioned competitors at all.

8.3 External governance, incentives and regulation

8.3.1 Regulation

One might have expected that the regulations which most impinged upon our study organisations, and of which they were most conscious, were those regulating the central tasks in conducting and developing an enterprise: regulation of safety and service quality, planning permission, probity, environmental health and safety and so on. Far from it; our health sector informants most often mentioned more arcane regulations which they saw as needless obstacles to their ideas.

NHS Pension Scheme rules were the most often mentioned. Those regulations prevent a 'profit-making' organisation's members or employees being a member of the Scheme. Our informants were willing to sacrifice other proposals and aims in order to retain the pension that the Scheme provided. At NurseLed it was proposed to recruit a non-NHS Director (from the parent social enterprise) to the Board but if that happened the practice board members would no longer be entitled to NHS pensions and neither would practice employees:

We couldn't understand why they couldn't accept the company limited by guarantee. But for some reason it has been left out of the wording in the NHS Pension Act and that means if doesn't count so we had to reconstitute the company.

(Board Member, NurseLed parent organisation)

This took about a year to resolve.

Also because of NHS Pension Scheme regulations, Metro was constituted as two organisations in parallel. (Different regulatory complications made Traidcraft adopt a similar structure (293).) The former cooperatives (which merged to form Metro) were neutral trading organisations whose accumulated operating surplus has by law to be returned to its members. In the eyes of the NHS Pension Scheme that made it a profit-making organisation. Thus a parallel non-profit-making organisation, whose members can be in the NHS Pension Scheme, was set up to undertake Metro's current services. The older organisation owned the buildings which the new organisation used, and those remained the property of the old organisation's members. Such was the complexity of these regulations that

we have to go to the Pensions Agency conference and forums to actually understand all the pensions requirements and regulations and get that on board 'our organisation.

(Finance Director, Metro)

Given its level of income, City could not afford to participate in the NHS pension scheme, substituting the cheaper benefits package of a private pension fund (6% of salary, which City matches), medical insurance (!) and gym membership. The other repeatedly-mentioned regulatory obstacle concerned the status of non-doctors as clinical principals. At times this state-of-affairs was merely a minor irritant, especially for the nurse-led NurseLed partnership:

We have stupid problems like the paperwork of the NHS [which requires] the doctor's name, it's doctor so and so's surgery. Our patients go to x-ray, "Well who's your doctor?" "Oh I don't have a doctor, I'm registered with [NurseLed]" "Yes, but who's your doctor?" "Well, I don't know, it's been a new doctor". "But we need a doctor's name in this box!" Why?.

(Nurse partner, NurseLed)

The Quality of Dispensing scheme had its own funding and annual monitoring meeting with PCT, which the PCT wanted a lead GP to represent the practice just because that was what the guidance stipulated, even though the relevant lead partner at PharmPlus (with specialist knowledge in prescribing) was the pharmacist partner not a GP. PharmPlus's nurse practitioners could make secondary care referrals but it remained unclear whether the pharmacist partner could, or order X-rays.

Similar regulatory irritants restricted the role of the OOH cooperatives with occasionally 'stupid' effects so far as the management of walk-in patients was concerned. The OOH cooperatives were supposed only to deal with telephone enquiries:

In the surgeries you [patient] can walk in to your surgery and talk to them [doctors]. If you walk in here, we can't see you because then you mess up the whole thing and we have to ask them [walk-in patients] to go back home and make the call. Sometimes it is so stupid because the patient goes outside, they make the call!.

(Finance manager, City)

Indeed, out-of-hours patients were officially supposed to receive the service only if they 'phoned from their own home:

The reason is, traditionally, the doctor wouldn't visit you if you are not at home, therefore if we visit, and you are not at your address, they [PCT] refuse to pay for it. It's silly, when you explain it to the patient, why they need to be at home, you just sound so stupid.

(Finance manager, City)

This situation apparently arose because the OOH service is regulated as an extension of general practice not as a service in its own right.

Pharmaceutical regulations also had a big impact on the development of some of the organisations studied. On the positive side, the regulations also enabled the participation, on a more equal footing, of non-medical clinicians as partners in general practices. It was practically very important to their job that the NurseLed nurse practitioners could be independent prescribers. Revisions to the independent prescriber regulations had also made it possible for the pharmacist mentioned earlier to function more independently as a clinician. Despite these positive changes, the

pharmaceutical regulations could still complicate, even impede, service developments. At PharmPlus the one pharmacist in this small country town retired. His business was too small to sell on so PharmPlus practice applied for the vacant pharmacy licence but found that GPs aren't permitted to hold them. They therefore set up a parallel private company (PLC) to hold the pharmacy licence. Its shares were divided among the practice partners in the same ratio as their partnership shares, and the partners were its directors.

This company also owned the practice's land and buildings, which required redevelopment. The PLC had to work out how to finance the building until there was an income stream. The answer was to claim VAT recovery whilst the building work was under way (a common practice outside the health sector). Similarly, NurseLed's building were owned by a parallel limited liability company with the practice partners, and a representative of the parent social enterprise, as its directors. The parent social enterprise negotiated the actual purchase of the premises. Arrangements at PlusPM were simpler. Its building was owned in equal shares by three partners, but the others had the option to buy into it in future.

The reason for these convolutions lay in the legal nature of the partnerships:

As a partnership you are individually and separately liable for everything so if you have got this building which has like a £1million plus mortgage on it, you don't want to hold that as your personal liability and risk. But having it in a limited company, the company holds the risk. .

(GP, PharmPlus)

The Metro cooperative also set up and maintained its residual property owning company purely because of the pension regulations, although for all practical purposes it was superfluous, as did City when it won a contract to run a Darzi 'polyclinic'.

Outside the health sector, the regulatory framework for legal partnerships was being brought closer to that of general practice. The Legal Services Act, due to apply from 2011, will allow a limited liability partnership to operate as a company and generate profit for capital growth rather than for drawings (payments to partners). It also allows for non-lawyer partners (a similarity to PMS in English general practice). Our legal partnership study site were already planning ways of taking advantage of this change. For our building society site, the Building Societies Act 1986 greatly broadened what a Building Society could do. The FSA regulations which our informants thought most important for them stipulated certain managerial ratios, reminiscent in some ways of the NHS planning norms and ratios in the 1980s. The Building Societies Association stipulates that three-quarters of building society of assets must be invested in retail mortgages and half the funding must come from retail customers. For the small food retailing cooperative, the most important regulatory event was the possibility (from the 1970s) of registering as an industrial provident society. Previously its

members had collaborated as a cooperative, but used the legal status of a private company which meant that the houses of the few members who owned houses were at risk if the cooperative ran into trading difficulties. Registration as an industrial provident society removed this inhibiting danger. The cooperatives were also bound to apply legislation concerning employment rights and equal opportunities. Wholefood concentrated its efforts in the area of employee appraisal

an activity which had also been a requirement of its 'Investors in People' activity but was also maintained 'so that you know if you do have to sack anybody, you've got a clear record, so you've kind of got to cover your back.

(Member, Wholefood)

For this cooperative, member appraisals were (as one might imagine, given its egalitarian principles) 'a nightmare'. To make appraisals as objective and impersonal as possible, the cooperative eventually devised the survey system described above.

Our building society study site relied heavily on non-executive directors to conduct external scrutiny of how far they were adhering both to external norms and to the members' interests:

we have to have a majority of non-executive directors unlike corporates, so there are weaknesses in the mutual model in the fact that we are not accountable to scrutiny of analysts, the shareholders etc ' but there are lots of benefits that we've talked about in the longer term etc. It therefore places a greater degree of responsibility, I believe in accountability to ourselves [managers], so it is important that the non-executive directors challenge the Executive to act in the best interests of the Board.

(CEO, HouseLend)

Notice that the absence of shareholder and analyst scrutiny was seen as giving managers greater responsibility, but this also implied greater discretion (see above).

8.3.2 Contracts

How contracts were formulated was a more important question for the general practices and OOH cooperatives than for the other organisations we studied, because the other organisations' income did not rely mainly on just one (contract.

Providers preferred less complete contracts because they left more flexibility to innovate. This was why the PharmPlus partners wanted to keep a PMS contract rather than (as they saw it) the more 'dictatorial' APMS contract. The PMS contract allowed a more predictable cash flow and flexibility, since it had enabled the practice to recruit a non-GP (pharmacist) partner. Even the PMS contracting system, though, had difficulty accommodating the role of different professions in this partnership. Another problem was that of standardised contracts requiring what the providers saw as superfluous activity. Thus at PharmPlus:

part of QOF is that they [patients] have all the tests, you know.

(employee, PharmPlus)

and at NurseLed:

to reach the QOF targets is not that difficult. 'We are approaching things the wrong way because ticking a box for blood pressure and checking that the patient is healthy but if that's what you've got to do to get the income to run the Practice with, then that's what we have to do.

(NP partner, NurseLed)

From the PCT's point of view, it was important in justifying their decision to set up a nurse-led practice that this contract had been awarded in an open (nationally-advertised) competition.

Duration of contracts was mentioned in two contexts. First, a short-term contract makes it easier for a corporation with large financial reserves to bid low for an initial contract in order to drive out competing NHOs who don't normally have large financial reserves. The same applied to the cost of preparing contract bids, which the Managing Director at one OOH cooperative estimated at tens of thousands of pounds per bid. For the much smaller general practices, the requirements of bid preparation were a deterrent to bidding. Second, the contract duration has to be long enough to enable bidders, including NHOs, to plan and finance the provision of buildings and other expensive equipment. In both general practices and OOH cooperatives the imminent end of a contract puts what might be called a contract blight on capital developments. Metro acquired the building next door to their headquarters but were not at first able to use it because the building happened to come on the market 12 months before Metro's contract end:

Two years wasn't enough even for buying cars, let alone making significant investments in buildings and IT and that kind of thing.

(clinical governance lead, Metro)

The PCT therefore agreed that the next contract would be for 5 years. NurseLed's short terms (3 to 5 years) of PMS or APMS contracts also prevented NurseLed's parent social enterprise from bidding for further NHS contracts because they could not solve the problem of obtaining premises. Short term contracts thus made capital financing hard, again favouring corporations with large capital reserves.

Exacerbating these uncertainties, problems with letting Metro's contract renewal led first to the original two-year contract being extended for a year, but then the new competition was aborted on the day of the interviews because one of the PCTs withdrew from the commissioning consortium; our informant said, ten minutes before the interviews were due to start. The competition for a contract from another PCT was aborted the day before interview, although at least in this case an explanation was given i.e. that they needed now to consider how the out-of-hours service would relate to the newly-announced GP-led health centres ('Darzi clinics'). An effect of contract insecurity was to encourage Metro to diversify its activities to give

them a safety net rather than depend solely on one large contract. Having spare call handling capacity, they offered call answering for a translation service for example and for district nurses (and said they could also offer it for out-of-hours dental service). At the time of the fieldwork Metro were also considering selling advice and consultancy services to other out-of-hours providers.

The main practical effect of the contracts were in incentivising specific activities and targets. For the general practices, the QOF scores were cited in every case. The use of QOF and GPAQ scores as contract targets was however well-received in all the study general practises because these indicators gave clear feedback, were rewarded with income and were definite, so that all could see when they'd been achieved. In the out of hours cooperatives, the national out of hours quality standards were thought to have similar virtues.

8.3.3 Guidance and governance

NHS guidance and policy are implemented partly through contracts (see above) but also through providers' networked and quasi-hierarchical relationships with external governance bodies such as PCTs (108). For the general practices in this study, implementing national policy was sometimes seen as an extraneous chore:

Choose and Book, was difficult in the beginning, very time consuming. The initial stage that the doctor has to do when the patient comes in, is quite time consuming, best if the GP does it face to face when the patient is in the room. In this practice there's a target of 90% of our referrals by Choose and Book.

(employee, PharmPlus)

Practice-based commissioning had created a lot of extra work for my staff with regard to the actual paperwork, it has intruded into my consultations where I am cursing at a piece of software that doesn't work properly, depending on how one hospital has put on their consultants or their specialities [which] will not be the same as another … So national policy usually hasn't helped a lot. We have carried on doing what we have always been doing.

(GP, PlusPM)

Provider diversification policy complicated management for the NurseLed practice. Although the PCT wished to retain (in effect) a directly-managed primary care service, the main effect of the provider diversification policy was to add an organisational layer to produce an organisational separation between the PCT and the services it no longer line-managed. For NurseLed, the intermediary organisation was a social enterprise constituted as a limited liability company, although as noted above this arrangement eventually broke down and the practice reverted to having a direct contractual (APMS) relationship with the PCT. These arrangements contrasted with those at PCTrun which, during the time of our fieldwork, remained directly managed by the PCT.

The study organisations' knowledge of current policy priorities tend to be filtered through their commissioners. In widely separated sites our informants gave the impression of being overloaded with policy guidance and imperatives. This applied both to the cooperatives:

It seems like every other meeting [with the PCT]'they have got something new that has come up. There is always another policy from somewhere. 'We see it as PCT telling us, PCT has come up with something else but we understand that these things come from the top.

(Finance manager, City)

and to general practices:

Most of what we feel negative [about] at the moment is down to, coming down from, government. Choose and Book agenda, practice-based commissioning agenda, lots of initiatives that seem to be put into place without any thought of who's actually going to do the work anyway, chaps. The IT, central spine, the data protection.

(manager-partner, PlusPM)

However our financial sector study site experienced a degree of external quasi-hierarchical scrutiny without parallel in the NHS. In late 2008 and early 2009 the FSA were asking for twice daily reports on the net inflow and outflow of cash from the society.

8.3.4 Effective regulation?

On the positive side, adherence to external regulation was assisted by the content and form of the external targets themselves. QOF, PACT and GPAQ all involved clearly-defined, detailed targets with correspondingly elaborate data collection systems to provide the necessary data. The specificity of these targets allowed identification of specific concrete activities to improve services. No less important, the content of these targets were seen as legitimate because they accorded with values strongly held by GPs and other health workers (to make patients better, give them a good experience, build up a relationship with patients). The clinical targets were based on evidence (albeit of varying strength) or at least clinicians' consensus about good practice. Hence the targets appeared 'objective', not based on an arbitrary decision or negotiated deal. They could be used internally to scrutinise and persuade doubters and 'free riders', and to satisfy external scrutiny. The targets were set at levels which the provider could achieve (perhaps too easily) and it mainly depended on the provider's own efforts whether it did achieve them. Not least, achievement was rewarded with non-trivial amounts of money.

A prerequisite for external, as for internal, governance is transparency over the activities over which governance is to be exercised. The general practices were linked into quite structured and standardised information systems intended to generate data to enable external accountability (in the first instance) their PCTs. The three systems mentioned at all three sites (and the fourth, hierarchical general practice that we studied): the Quality and Outcomes Framework (QOF) which is an adjunct to the 'new' GMS

contract of 2004; the PACT pharmaceutical monitoring system; and the GP patient survey. These data were fed back to the PCT. For their respective domains these three systems enabled the PCT to compare each practice's performance on a consistent basis with those of other local practices, and with regional and national patterns. For the OOH cooperatives, external financial monitoring and service standards monitoring were equally frequent. Metro made its accounts transparent to its commissioning PCTs one of which sent its own accountants to examine them. Its PCT, with (at that time) a cost-based contract with Metro, used the information to identify costs to remove, including the Metro's contingency fund. City sent monthly activity reports to the PCT every month and had face-to-face monitoring meetings every quarter. Because of recent corporate failures in the financial sector failures (of which some of the most conspicuous were failures of ex-mutuals) our financial sector study site was at times exposed to requirements for transparency far exceeding those of the NHS. HouseLend was bound by Financial Services Authority (FSA) rule. Fearing further business collapses, the FSA were during 2008 asking for twice daily reports on the net inflow and outflow of cash from the society, as from all FSA-regulated businesses. In the USA (as in the UK), new regulatory frameworks accompanied the development of information technologies. This addition of this framework, reinforced by a wish to maintain commercial confidentiality, paradoxically meant that the more powerful IT reduced the transparency of OverThere's work to its members. All its Board meetings used to be held in public but now, data protection and business confidentiality mean that only inconsequential things were now discussed in public. In summary, partnerships' and producer NHOs' goals were to break even at a level that gave members or partners and income at least as good as the prevailing market rate; to produce what they defined as good quality work for their locality; to assist members' or partners' personal development; and to pursue non-financial values which varied by organisation. Consumer NHOs' goals were to reduce the price and raise the quality and accessibility of services for their members. The study organisations had to contend with legal and regulatory systems designed mainly with for-profit, shareholder-owned firms in mind; and with what they experienced as excessive amounts of policy guidance. The most effective form of contractual governance was through contracts whose terms were unambiguous, legitimate and incentivised.

9 Structure: case study findings

This chapter reports not only the study organisations' formal structures, but how these structures were used to manage the organisations, how sustainable the structures were, and how they intersected with professional cultures and engagement.

9.1 Coordination strategies: modes of democracy

9.1.1 Members and their rights

In partnerships, the question of who could vote to elect the organisation's leader was straightforward: it was only the equity owning partners. Partners' meetings were generally closed to employees and in one site (the legal partnership) closed even to the partners who were not elected representatives of the rest, which may explain the discrepancies in the accounts which different partners gave us about how decisions were made. At the architectural partnership the five (pre-merger) partners had equal shares of equity although different levels of responsibility for managing the partnership.

In one of the out-of-hours cooperatives salaried doctors only counted as members if they worked at least half time for a practice in its territory. The Board of Directors consisted of GPs. The local PCT sent an observer but she could not vote in elections to the Board or at Board meetings. Metro membership was open to all GPs practising in the PCTs covered by Metro, including GPs who had ceased working sessions for the cooperative.

Wholefood members were a mixture of volunteers and paid members (initially three or four) working in a food shop and cafe. Every member had the right to propose policies and decision, even (in principle) to propose cessation of the organisation. By the time of writing they had expanded their membership to around 60, in three categories: 46 working members, hence directors; 5 probational members; and casual employees, whose number could not exceed 5% of the cooperative's labour force. Bigshop members were all those on the permanent payroll.

HouseLend members were eligible to vote at the AGM if they held savings over £100 or had borrowing (mortgage) with more than £100 owed. The constitution stipulated one member one vote, with the first named on any joint accounts being the voting member. The account holders choose the sequence of names on any joint account. OverThere members were those who subscribed individually to one its insurance plans.

9.1.2 Engagement

In the cooperatives (but not the partnerships) there could be a substantial difference between the membership who could vote and those who actually did. The highest level of participation appeared to be in the two retail cooperatives, especially the smaller one. Although approximately a hundred times more numerous than the average GP partnership, Metro and City members met less often, participated much less evenly and had less control over day-to-day practice (quality, working practices, hours of service etc.) than in a general practice. Their annual meetings were (we were told) more like a shareholder's meeting than that of a work-team. For the members were mainly busy GPs who found it difficult to spare time to attend meetings, especially the regular attendance required for Board membership. From a low starting point, AGM attendance at City did rise during the study period, which the EO attributed to the increasing scale and pace of change in general practice making GPs think their attendance was becoming more necessary.

Member engagement was weaker in the consumer cooperatives. OverThere had only 30,000 voting members, of whom only about 6000 actually voted, and that number was declining. Members' local meetings were often quite limited and basically consisted of information-giving by employed clinicians and managers on subjects of the local members' choice. Members' other meetings, above all the Medical Centre Advisory Councils , took place six times a year. There was uncertainty about their role and it seemed to be diminishing. Board meetings' serious work was done in private now, where once it was public:

The governance in truth has always been the Board of Trustees. That's the governance.

(Senior Consumer Caucus member, OverThere)

The Senior Caucus was the only Special Interest group still operating (there have been at least two more during OverThere's history), although it was very active.

Below Board level in OverThere were Medical Centre Advisory Councils (MCACs), of which there were 16 when we collected data, based at local medical centres. Each MCAC comprised nine elected consumers, the manager, medical chief of staff and nursing director of the centre. In theory MCACs monitored the centres' budgets and quality of care but our interview data painted a slightly different picture. The chair of one MCAC gave feedback at the Advisory Group Assembly (ASA) pointed out that directors or staff of the clinics used to always be present at the MCACs but now the Chief-of-Staff and manager will come, briefly give their reports and then leave without taking questions or comments. One member didn't think much of that:

'The MCACs are here to give advice 'how can they if staff aren't there? We give up OUR time as well as they giving up THEIR time - It's only six meetings a year, why can't they stay?' (Advisory Council (MCAC) Chair,

OverThere). HouseLend claimed approximately 560,000 voting members at January 2009. Two levels of engagement were available to them. They could vote by post on resolutions put the AGM. About 20% of eligible members do so. We were told this percentage is higher than in most mutual building societies. Also, members can attend the AGM and speak. Only about 30-40 qualifying members do so, below 0.0001% (one in 10,000) of the eligible members.

Engagement in the Wholefood retail cooperative was as frequent and direct as in the partnerships. Each work-team (typically not larger than 8 members) sent a representative to a fortnightly representative forum meeting whose purposes were to hear items of news or problems reported back the work teams; and on behalf of the whole membership to make policy and other decisions.

Members' engagement in the study organisations appeared to be promoted by:

1. Geographical concentration of the membership.
2. The practical importance for members of the decisions which members' meetings took.

How far members' activities appeared to influence the management, activity and direction of the whole organisation.

9.1.3 Election

We found the following methods of selecting members to take on leadership and other responsible roles:

1. Rotation, with consensus about whose turn is next. At PharmPlus the partners agreed a 'Chair of the Day' held for one year in rotation. In Metro the five medical directors of the executive took turns to cover weekends as director on call. Within work-teams in the small retail cooperative the roles of representative, minute-taker etc. were rotated:

the idea being that we are sharing and diversifying... so you don't find somebody sitting in the same role unduly for year upon year upon year upon year.

(Member, Wholefood)

   This rotation also applied to representing the work group in the organisation-wide decision making forum.

2. Volunteering as 'lead' on the basis of personal interest or competence, subject to consensus endorsement. So for example, the pharmacist partner at PharmPlus volunteered as lead on HR matters. At PlusPM the partner-manager took the lead on liaison with employees and on meeting external targets, finance, computerisation and dealings with PCT since he had greatest knowledge of such things. Whilst the council of City was elected, its three GP members who were on the Board were

selected by consensus when a vacancy occurred. Even for council members there was an element of self-section:

I think most council members have come because they've got issues that they think need to be dealt with 'things they want to change.

(Finance Director, City)

3. Seniority, as founders of the organisation. This common arrangement in medical partnerships was also found at NurseLed.
4. Election. Metro members elected the Board of Directors, which was therefore seen as accountable to the members. The Board consisted of GPs and a Managing Director. In Metro any GP member could be nominated for the Board. The executive team were accountable employed by, hence accountable to, the Board. The council of City were an elected group of 15 who selected three Board members. The Council were all GPs, five from each of the three boroughs which City served:

every year it comes up for nomination, we ask people, we send papers round, we say if you want to be a council member, 3 seats are available, put yourself forward. They write a statement and send it out to everybody to say these are the people that have come forward, who would you like to vote for?.

(Finance Director, City)

The Company Secretary and the Chairman were also members of the council.

The HouseLend Board of Directors was elected through proposals from existing Board members, or through professional contacts such as solicitors and accountants. Sometimes a search and selection company was involved. Because support had to be gathered from 200 or 500 members depending on the nature of the resolution, it was harder for members to nominate candidates:

there's a route by which members can get resolutions and can put forward directors but obviously because of all the data security and sensitivity, their ability to gather a sufficient number of names isn't very easy and it also depends on what that resolution could be and what it's about.

(Secretary of the Society, HouseLend)

The legal partnership had a board of six partners with a Chair, the latter being elected by and from the Board members. Each put themselves forward if they wished to stand for election. A merger with another partnership had occurred on condition that the managing partner of the acquired partnership became a member of the Board to ensure that other pre-merger agreements were adhered to, until the next election when the board reverted to its original form. The accounting partnership had a mixed board, four elected and three appointed. The architectural partnership elected the members of its board and who, after the partnership merged with another one, sat on the combined board.

The largest study organisations had correspondingly elaborate electoral structures. Four-fifths of the board members in the large retail cooperative were elected, one-fifth appointed by the chairman. The majority of Board members are elected by a Staff Council, of whom in turn at least two-thirds are elected yearly by secret ballot of the whole Partnership Any member can stand as a candidate for election to the Board. Elections take place every two years. Thus the members indirectly elect the majority of Board members and the Chair.

OverThere had a Board of Trustees with 11 members including a Chair. Its official aim was to oversee and monitor the well-being and accountability of the organisation by establishing organisational goals, setting policies, monitoring the fiscal affairs of the Co-operative, employing necessary personnel, and assuring the quality of the health care services provided to consumers. It had various specialist committees e.g. for audit, pay, quality and 'emerging issues' (short and long-term business goals). A standing Nominating Committee of 10 consumers recruited candidates to the Board of Trustees. Board election had become increasingly carefully managed. The Board of Trustees information officer (manager) explained that ordinary folk could no longer be elected to the Board, as they could ten years ago. The management now meet with the Standing Nominating Committee (SNC) to discuss what types of candidates might be 'useful' for the Board. The criteria of usefulness are neither published nor widely known. They received 159 enquiries in 2009, yielding about 50 serious applications. These were then vetted for criminal record and employers' references, also for their qualities and experience. The SNC drew up a short-list of these candidates and then publicised their candidatures in bulletins posted to members' homes, a presentation and the cooperative's website. One of our own informants had put himself forward as a candidate and was not selected (no reason was given to him). Coordination strategies for the study organisations were therefore rather circumscribed modes of democracy in three respects:

1. An electorate extending only to equity partners is in effect a democracy with a stringent property-qualification, comparable to the election of English MPs before 1689. In large partnerships this electorate was only a small proportion of the workforce.
2. Rotation is an non-rational (i.e. neither rational nor irrational) procedure similar to sortition. However it has been argued (339) that in egalitarian terms, in fairness and as a mechanism for securing representative leaderships sortition (and by implication a similar organisational structure) is not necessarily inferior to election, especially when the people from whom leaders are selected are more or less equally competent. Such organisational structures are neither democratic nor hierarchical.

In the consumer cooperatives especially, member control was liable to degenerate in face of managerial control. We return to this point below.

9.1.4 Decision-making

The general practices we studied had a common sequence for decision making. Closed partners' meetings first made a decision, followed by discussions with the employees, usually at periodic practice meetings. Internally the partners' meetings generally worked by consensus. For instance the Legal Board meetings almost always reached decisions this way. Usually the decisions had already been discussed beforehand and were simply adopted without the need for a 'Show of hands' vote. In this type of direct democracy, taking a vote was paradoxically regarded as a failure. It had happened only once since 2000, about the cost of potential new premises. Since the board was almost evenly split they decided that the proposal was too doubtful and dropped it.

NurseLed adopted a more open approach. The partners had a non-hierarchical style of management, with consultation always, and at times employees voting on changes in working practices. Weekly staff meetings voted on proposals suggested during the previous week. More weight was given to the views of the staff who would be undertaking the tasks being discussed or changed:

The team leader said to us, because we are the people that actually do the work, 'How do you feel that would work? Which way do you think would be the best way to go forward with that?.

(employee, NurseLed)

In Wholefood (all important decisions were taken at meetings open to all members:

We depend on meetings. Obviously, if you don't come to meetings, then we're not having your say in the business, so therefore you shouldn't carp about decisions that are made because you're not there.

(Member, Wholefood)

However even these principled supporters of direct democracy agreed that such decision making processes are practically limited to smallish groups:

It's very difficult to work a group size above about eight; eight people is about the maximum you can have in there [for] conversation and dialogue and come to decisions.

(Member, Wholefood)

Each such meeting elected a delegate to a cooperative-wide body which (made two kinds of rules: foundation rules which were included in the cooperative's registration document and secondary rules which prescribed the more concrete, mundane work practices.

Decision-making in the out-of-hours cooperatives devolved much more upon an elected minority of members and employed managers. Decisions at Metro were made within the Board of Directors and at regular meetings for members. A quarterly Board meeting endorsed the decisions of an executive team which met monthly and had sub-groups (e.g. for clinical governance). Things that significantly affected the future of Metro, like a

tender bid and decisions to buy property, had to be fully discussed and endorsed by the board. Ad hoc member meetings (less frequent than the regular meetings) also dealt with clinical governance and premises issues. At City, Board meetings appeared quite open to proposals from the members, the source of many small (and some big) innovations:

it was a question of other doctors coming up with suggestions or ideas of what we could be doing … so whatever people came up with, we would just look into it and see if we could go. The new one that has come up now is practice-based commissioning so we are looking into what we can do.

(Finance Manager, City)

In the large retail cooperative, decision-making powers were distributed across bodies stipulated by a founding constitution i.e. a Board, a Chairman and a Council.

1. The controlling Partnership Board had their own powers under Company Law. They openly discussed and decided policy issues, even matters of business reorganisation and redundancy. The Board had to approve any reorganisations or closures involving the loss of 12 or more posts.
2. The Chair (of the Board) was Managing Director with 'those of the powers of an owner-manager that … it seems necessary to concentrate in one pair of hands.' (Founder, BBC broadcast, 15 April 1957). The Chairman could can veto a Council decision if in he judged it dangerous to the organisation's business interests.
3. The Staff Council had about a hundred and twenty members. It represented all partners and elected five directors to the Partnership Board (see above). This Council had unlimited rights of discussion and recommendation, including power to pass votes of confidence (or not) in the Chair. It had to vote by secret ballot if so required by any member or by anyone else principally interested in the particular matter. It had a small budget at its own disposal.

The cooperative operated on explicitly democratic principles under a written constitution guaranteeing freedom of speech. Every branch of the retailer and its support services had a Committee for Communication elected by and comprising non-management Partners.

In the consumer cooperative, decision making devolved almost completely upon managers, who reported to an annual general meeting. In recent times the business element of the AGM took well under an hour, the rest being given to questions and answers and a presentation by a visiting speaker. There were also member councils to exercise governance at the more local medical centre level (see above).

9.1.5 Speed of decision-making

In the partnerships decision-making was quite swift when need arose. So, when PlusPM practice had to decide whether to recruit another doctor;

We had a strategy meeting last night with the partners and I pulled the... notes together, what I think we agreed, all the partners have got a copy of those now so hopefully by Friday we will all have agreed what we agreed and then we can share that with staff on Monday and move it forward.

(PM-partner, PlusPM)

Formal decision-making was inevitably supplemented with informal, chance contacts during everyday work.

The large retail cooperative showed no sign of slow decision-making, we infer because its Chair and Board could take decisions without immediate reference to the members, subject to post facto endorsement (or not) only through the structures described above. Three other Co-operatives were conscious that their decision-making could be slow. City therefore revised the constitution to speed up decision-making at Board and Council meetings by delegating the more trivial decisions (see below) to managers. OverThere publications stated that the cooperative had not responded and adapted sufficiently swiftly to market changes, especially competitors' entry to its markets:

The leadership's assessment of this problem is that [OverThere] is still too expensive and too slow in responding to changes desired in the health care marketplace. For example, in 2002, there were five Medicare insurance products in the [name of state] market and [OverThere's] was the dominant one. By 2007 There were 100 such products and [OverThere's] was no longer dominant. The goal is to turn that around.

(Newsletter, 2008)

One manager suggested ('off the record') that slow decision-making was a legacy of the cooperative ideal. The Board and top managers needed endless meetings because no-one could decide things on their own initiative.

At the opposite extreme in size, Wholefood made decisions on the basis of consensus which meant that major decisions had to be unanimous. It had a distinctive method for resolving conflicts of interest among members. Within the existing legal and regulatory requirements (e.g. for fairness and confidentiality in deciding personnel issues),

Our process is that there is a period of time identified to discuss it, after which it goes to workshop; the workshop is to be outside of the meeting time and interested parties basically know their responsibility is to sit down and thrash out some kind of compromise. If you reach the situation where even after workshop there's an impasse, then ultimately then it has to go to the forum...for a double blind vote.

(Member, Wholefood)

Another member told us that someone who had worked as a manager in a hierarchical organisation probably would at times find decision making slower than she had been used to, even frustrating. Nevertheless, we were told that consensus decision making has never held the cooperative back in any practically significant way. The cooperative had after all survived and grown for forty years and the same applied to the far larger OverThere consumer cooperative.

9.1.6 Mutual scrutiny and concertive control

Some of our informants were conscious of the 'free rider' problem even if they did not so describe it:

One of the most difficult things in a co-op is the member that isn't pulling their weight.

(member, Wholefood)

Members of this small food retailing cooperative certainly noticed who did and who did not pull their weight. However, they tried to prevent such issues coming up at meetings 'because obviously that's just dead loss' (member, Wholefood). Instead the cooperative tried to encourage its members to be assertive with one another in dealing with such problems, even to the extent of providing training in it; an indication of how important they regarded this approach as being since the cooperative could only rarely afford training activities. This cooperative had a distinctive, systematic approach to mutual scrutiny. Every member had an annual review in which every other member of the cooperative voted (anonymously) on her performance:

So the chances are that unless you are a very thick skinned or stupid individual that is a hundred people are telling you that you are doing your job well, or a hundred people are telling you that you are doing your job crap, you'll take that on board.

(member, food cooperative)

The aggregated survey results were also used as an indicator of job satisfaction across the organisation as a whole.

In the general practices everyday working systems would often expose such a member. Although speaking of locums, this GP in PharmPlus described systems that applied to all the partners too:

Internally, the dispensing system spots any aberrant prescribing by locums; so do practice staff. Not all locums like this.

(GP partner, then chair of the day)

The same applied to referrals. For all the general practices studied, PACT information allowed partners to scrutinise each other's prescribing practice. Although they encouraged continuity of GP through each patient episode, PharmPlus GPs had no personal lists. Hence each partner's practice was transparent to the other partners by way of the patient record and patients' own reports, which would at times provoke discussions between the GPs. Partners at PlusPM established the practice of meeting in one room at lunch-time to do 'paper-work' (nowadays mostly computerised), deliberately creating opportunity for informal discussion. Both there and at PharmPlus partners' involvement in the PCG or (later) PCT caused friction with the other partners because the PCT-goer was often out of the surgery, leaving the other partners either to do work or pay a locum to. At PharmPlus, as one informant delicately put it, certain partners 'ensure they have no greater workload than others' whilst others readily took on extra tasks, differences said to reflect the individual partners' personalities. One

obstacle to mutual monitoring was that GP roles and functions had changed over the past five years making it less clear what constituted a standard level of commitment to the partnership. So the practices agreed policies about partners on taking on external commitments. PharmPlus developed a 'time off in lieu' spreadsheet recording how many sessions the practice owed or was owed by each partner and when the sessions were paid back so that in the long run partners' inputs were equal. In the much smaller NurseLed practice, 'We don't have huge amounts of formal feedback 'it's all relatively small, the organisation, really. People just talk to each other.' (Board member, parent social enterprise for NurseLed). Mutual scrutiny was least evident in the accounts of the (all salaried) GPs at PCTrun, with greater emphasis on the GP's own conscientiousness and self-discipline.

In out-of-hours cooperatives this scrutiny was more like that in an hierarchical organisation. The elected board member responsible would monitor activity figures for each shift. When complaints or disagreements arose,

It's normally easier with the GPs [than patients or employees] because they are doctors and they can talk to each other.

(Finance Director, City)

If informal discussions did not work the last resort was to stop the member working shifts for the cooperative. The systems operated at the large retail cooperative were essentially similar. It had a line management system which in these respects appeared to operate much as in a corporation. Individual members' level of performance was appraised through personal development plans of all staff. These plans were designed around achieving the Principles reported below. The principles were set as the performance indicators, and the measures were set at three levels of 'don't want to see'; 'want to see' and 'outstanding', built around a set of behaviours about what partners are expected to enact. OverThere employees were also line-managed much as in a corporation except for doctors, who had formed themselves in a semi-autonomous medical organisation contracted solely with OverThere. The rationale for this arrangement was never clearly explained to us, but its practical implication was that doctors were line-managed and mentored by other doctors.

9.1.7 Technical persuasion

Evidence-based practice is discussed below. The QOF, GPPS and PACT information systems were used internally as a supplementary form of mutual scrutiny to convince any doubting partner of the need (when it arose) for corrective action.

The large retail cooperative used Key Performance Indicators (KPIs), one of which was how quickly a product reached the shelf in a cooperative that has over 300,000 product lines. These KPIs were expected to be met via the partners even where they do not have a direct responsibility for a particular

process, such as the central distribution system. For example store partners would be expected to work with a distribution centre if there was a problem getting a product to the shelf and to partake in joint problem solving to develop a communication conduit in order to deal with operational issues.

That apart, technical persuasion took the form mainly of training and education, which were were used mainly in the producer organisations in much the same way as in corporations (but with a different content): to induct new recruits and to update members' technical working skills. A third use of education and training was more specific to NHOs. In the small retail cooperative and NurseLed:

The only thing we do is, we do team building and we spent a bit on staff team building because we see that as important.

(NP partner, NurseLed)

Team-building training also occurs in hierarchical organisations often, paradoxically, for much the same reason as in non-hierarchical ones. Such activities provide the skills needed for informal collaboration in relationally-democratic settings, above all, teams with no overall line manager and drawn from different sub-hierarchies (340-342).

9.1.8 Culture and ideology

In all the study sites informants described what normative assumptions ('mission statements', 'principles' etc.) were accepted in their organisations.

Several interviewees (in different rooms) asked about PharmPlus practice's goals pointed to a copy of their 'practice philosophy' pinned up on the wall. Although NurseLed was a partnership in structure it like the two OOH cooperatives adopted the 'social enterprise ideology' which featured in policy pronouncements at the time of our fieldwork.

The study organisations' culture had three main elements. One was a strong sense of locality;

We've always maintained that you need to have a local knowledge. (That's been our underlying principle 'is it has to be local knowledge.

(Managing Executive, Metro)

The second element was an emphasis on quality (see above) and upon the organisation being clinically led, in part a reaction to the members' experience of commercial deputising services. A third element was a culture of support and mutual aid with other similar local organisations, even those who might under NHS provider diversification policy become potential competitors.

In City a new chief executive recruited during the study period had attempted to change the culture. In his words:

Before, the culture was, we employ perfect doctors therefore the doctor is always right. And the doctor is what you focus on, what's good for the doctor is what you do. But with time it

has moved on to [the] patient and the big thing now is that the patients are the ones who are important, the patients are the reason why we exist. I've been surprised when the council has agreed to something where it would actually cost more money but is better for the patient.

(Finance manager, City)

A similar outlook was found in the OverThere consumer cooperative. There was a particular mentality amongst clinicians who worked for this organisation of wanting to 'Serve others'rather than simply 'Get rich'and to emphasise preventive medicine. They expressed an interest in socialised medicine and idealist politics; in some cases they expressed interest in a biomedical model that is less 双rthodox' in other cases they had a family history of working in cooperative organisations, or even in this very organisation. In more general terms, its publications state that it subscribes to the values of 'respect, scientific discipline, integrity, pioneering spirit and stewardship'.

The market niche for the small retail food cooperative was the vegetarian segment. It therefore tended to attract as members people wanting to work in an ethical, environmentally friendly organisation. The cooperative was not overtly political but we did involve itself in campaigns related to its core values and activities, for example the anti-GM food campaign. In the large retail cooperative, the founding principles (quoted in Appendix 1), and a handwork elaborating them, were widely disseminated and consulted. The values and principles of the cooperative were instilled into every point of the staff recruitment with potential new staff being tutored about the ethics of the cooperative. The unanimity with which our informants referred to them or even quoted them from memory was striking. This culture of philosophical and business differentiation is actively and positively encouraged by including 'in every conversation discussions of how to do things differently'. The founding principles have not changed, only the language of these principles has been contemporarised. Managers were repeatedly told that they are constantly accountable to Partners, particularly via councils and their sub committees where managers have to account for their business performance.

In the building society, an official organisational culture was equally evident but its formulation and presentation relied more on a marketing approach than in the NHS study sites, reflecting the different external economic systems confronting the different organisations. Its recent marketing campaigns sought to differentiate HouseLend from a bank by highlighting HouseLend's accountability to its members not shareholders. Another marketing mix element - removal of secure physical barriers between customers and staff - highlighted a further difference (with banks) in how HouseLend regarded its customers. Its staff were continually reminded of four core objectives: Enthusiasm, Fairness, Ownership and Trust. The CEO suggested that their mantra is 'to attract on price and retain on service'. Like other building societies, this one prided itself on probity and reliability:

The sector is proud of the fact that no customer has [over 150 years] lost any retail funds.

(CEO, HouseLend)

Many customer facing-staff had joined HouseLend from corporate banks. The CEO suggested that they noticed the cultural differences between the values of either kind of organisation, especially in how customers were approached with regard to sales. The mutual's norm was that customer priorities and needs were put first, before profit. Branches existed for customer service even though the branch network represented over 50% of the society's operating costs.

Differences between NHO and corporate cultures surfaced in two ways. One was the difficulty which ex-corporate managers had in grasping the rationale, and hence relevant performance indicators, of an NHO. In our building society study site the question of how much profit to earn exposed deep-rooted differences about the criteria of good financial performance management in mutuals and in corporations:

They [non-executive directors] get confused because they look at, they come from the outside world, from a PLC world and they... really struggle with do we give good value to members because it's a total red herring to say the value of the business was x at the beginning of the year and the value of the business was y at the end of the year and is that movement good or bad? It only becomes relevant if and ever we had to pay people out or converting ended [the society], that's the only time it becomes relevant, all other occasions it's totally irrelevant because we're looking after the interests and giving value to current membership.

(CEO, HouseLend)

OverThere members were also on occasions aware of the conflict between democratic (mutual, cooperative) and corporate approaches to management:

At one time and [now] less and less so, the members of the Board were influenced by the people who elected them, but that's no longer the case'he Board is almost 100% now influenced by the needs of the business model.

(Senior members' caucus chair, OverThere)

Ex-corporate managers were prone to respond to this difference in cultures by blaming the cooperative model for difficulties the organisation was currently experiencing (see above):

Soon it will come to the point where it's probably better to get the Board nominated. A lot of money and resources are spent on facilitating things like the Senior Caucus 'but is it worth it?

(Manager, OverThere)

9.1.9 Material incentives

Pay was used as an incentive in three main ways.

1. Distribution of operating profit among partnership partners.
   (a) The default mode in the general practices we studied was an equal division per capita, but other partnerships (including those outside the health sector) used other criteria. The greater the proportion of operating profits was in partners' pay, the more an directly an equal allocation of profits transmitted external market

incentives directly to the partners.
(b) In the large retail cooperative, operating profit nett of the partners' fixed salaries and other costs was divided equally among the partners as a bonus. Hence the market-sensitive bonus was a proportionately bigger component of pay for staff on lower than on higher salaries.

2. Payments per session, for GP members who worked shifts for the out-of-hours cooperatives. In both cooperatives payments for the least popular shifts were raised to up to twice the payment for the more popular shifts in order to attract volunteers. The cooperatives established the necessary payment levels by trial and error.
3. Salary, gradated by position held (occupational group, supervisory versus non-supervisory) and, in the retail cooperatives, supplemented with payments for dependants and other individual 'needs'. The latter payments were discretionary. Wholefood could (and did) withdraw them from non-compliant or 'free-riding' members.

In the partnerships and the small retail cooperatives, the prospect of recruitment as a partner was also applied as an incentive. Our sites made no use of the 'tournament' ('up-or-out') system reported elsewhere (33,115). At PCTrun the salaried GPs regarded the absence of strong financial incentives as a benefit, enabling them to concentrate on clinical work:

The money isn't the most important thing at the end of the day.

(GP, PCTrun)

An important distinction between NHOs and partnerships was the disposal of equity. In the cooperatives and mutuals (including building societies unless and until they converted to banks), none of the members stood to gain from a shareholding if the enterprise were closed or sold off assets. Thus, if ever the Wholefood fails, any remaining money has to go either to another co-operative or towards re-starting the original cooperative.

9.1.10 Exit

Explusions of members or partners were reported but exceptional. A manager and founding partner left the NurseLed when its managerial services were centralised into a parent social enterprise. PlusPM had lost two partners, (of whom one:

just handed in his resignation out of the blue as far as anyone else was concerned. He obviously had underlying issues which he felt couldn't be tackled or weren't going to be tackled, and that was quite painful.

(PM partner, PlusPM)

No recent departures of partners were reported in our third study general practice.

In City there were reports of board members resigning but as this was attributed to personality clashes not free-riding or disputed decisions. However Metro did expel working members who seemed not to pull their weight or to comply with collective decisions;

At the moment we have more doctors wanting to work than we have shifts to cover, so we can say to people, "Fine, if you don't want to do things our way then you can go and do shifts for somebody else.".

(clinical governance lead, Metro)

In WholeFood two of its founders were 'seedling members' who supported to aim of cooperatives and help set them up but, noting wish to work in every cooperative that they helped to found, left when it began trading. Otherwise the main potential exit route was the decision made after their nine months probation about whether they fitted into the cooperative, partly a matter of whether they shared the cooperative's values and partly whether they fitted what one informant called the 'Identikit' of members of that cooperative. Occasionally members left in other circumstances:

it's very rare but we yeah we've had in my time, all the [20] years I've worked here, I think we've probably only … sacked a couple of members or we've asked one to resign and we sacked another and that was, one was just sheer uncooperativeness - would not co-operate after what happened and it was finally presented to them at the meeting that you know, either they should conform or clear off, and they said "I'm clearing off" and took their toys with them er, and the other one was a gross, you know, misconduct where it was just there was no option; it was just instant dismissal.

(Member, small retail cooperative)

Bigshop had probationary and disciplinary mechanisms similar to those found in corporations since its structure was in effect a hierarchy with an elected leadership. Expulsions of members were unknown in the consumer cooperative (OverThere) and the mutual building society. Such expulsions would be counterproductive for the purpose of gathering subscriptions and, since members contributed little to the core process of a consumer cooperative anyway and (few participated in governance, probably have little impact on those activities either.

9.2 Management

9.2.1 Interfaces between democracy and hierarchy

The role of intermediary between members and employees had parallels with that of a boundary-spanner (138) and involved role-conflict. Usually in partnerships one or more partners would be selected as this intermediary. (In the temporary absence of a practice manager the inter-face role was divided among all the partners at PharmPlus.) Management arrangements at NurseLed had gone through some vicissitudes. Initially the practice had transferred large parts of its managerial work to its parent social enterprise, at which time a third partner, a manager by occupation, left. The parent social enterprise undertook payroll duties, overseeing and underwriting

practice finances, managing employment and health and safety, and purchasing the practice premises. Initially the signatory for APMS contract with the PCT was the parent social enterprise not the partnership itself. NurseLed paid a management fee and would have shared its operating surplus with the parent social enterprise had the practice ever turned a profit. However the parent organisation ran into difficulties and shed a number of its non-core activities including health care. After that NurseLed employed a Practice Manager.

At PlusPM the team leaders and one of the doctors (representing the partners) had regular meetings. The manager-partner was responsible for implementing the practice's business plan and converted the relevant national policy and technical guidance into working procedures. At PharmPlus the chair-of-the-day filled this intermediary role in collaboration with the employed practice manager. The practice manager described his job as 'being the meat in the sandwich' between partners, staff and patients.

Similarly, in Legal a managing partner and a senior partner were charged with running the partnership. Responsible to them were a finance manager and IT manager. Even among its legal professionals Legal partnership had a clearly defined hierarchy whose ranks (top downwards) were: Full Equity Partners; Limited Equity Partners; employed Associates; Assistant Solicitors; Legal Executives; and Para-legals. Promotion up the hierarchy was by line manager's recommendation.

In the OOH cooperatives, elected Board members were the intermediaries between the membership and full-time employed managers. City's CEO reported to the council every two months. Similarly in HouseLend, the posts linking the membership and the employees were those of the Secretary to the Society and the chief executive. The partnerships nominated managing partners as the interface with employees. In the accounting partnership each region had a managing partner who reported to a national managing partner.

Two opposite problems in managing the member-employee interface were reported. One was the risk of clogging this interface with trivia. At City over some years the practice developed of disgruntled employees appealing to the council when they didn't like managers' decisions. Thus the council was getting drawn into relatively trivial discussions such as deciding whether there had been an error in a person's shift payments. Latterly this practice has been prevented by the council insisting that the managers deal with such problems. An opposite problem that employees sometimes wished to avoid engaging with the members. At PlusPM several informants mentioned the passivity and non-involvement of staff at practice meetings. Mini-meetings between the partners and team leaders replaced regular full staff meetings for this reason. Employees didn't participate because (the manager-partner said) they considered that 'they weren't paid to think'. PlusPM employees said that they tried as far as possible to run their part of

the practice fairly self-sufficiently, turning to the partners as 'really more of a backup' (employee, PlusPMs) in the last resort.

A OverThere member also described a:

natural tendency, temptation on the part of the staff to avoid controversy, to avoid problems, to steer things into safe non-controversial channels and ways that will make their jobs easier and support the mission of the organisation as they see it'

(Member, OverThere)

9.2.2 Subjoined hierarchy

We were told two rationales for appending a subjoined hierarchy to an otherwise democratic organisation. One was, the level of work discipline, nay compulsion, which it can produce:

The vast majority of our services are provided by paid staff because the bins and boxes need to be dealt with at 6 o'clock in the morning and if you don't pay people they have a tendency not to want to do that at that particular time, strangely enough!... you can't have a discussion with loaders and drivers about what they are going to do today. That was one of the problems they had in [organisation], they sat down for two hours before they started work debating who was going to do what and consequently they never finished anything.

(Board member, parent social enterprise for NurseLed)

The other rationale was than a subjoined hierarchy gave some flexibility in size and skills at the margins of the (stable) member-workforce. This was why Wholefood employed a maximum of 5% (in terms of hours per week) of temporary casually-employed staff.

Health service hierarchies are traditionally organised in occupational 'silos'. In western hospital systems the medical 'silo' has often been 'semi-detached' from the others and enjoyed certain privileges: high pay, less onerous performance management and a degree of collective professional autonomy. The general practices we studied conformed to this pattern. The private architectural partnership developed (partly by merger) a growing subjoined hierarchy of staff to take on activities that the architects themselves felt less interested or competent to do, not only quantity surveyors and structural engineers but also business managers and marketing staff.

9.3 Managing the subjoined hierarchy

Within each occupational 'silo', management was much as in any hierarchy, but with certain qualifications. Some methods of management applied in the hierarchical part of the hybrid organisations were similar (i.e. evidence-basing; appeal to culture and values; recruitment and expulsion) were similar to those employed for coordinating non-hierarchies and are therefore reported above.

A relatively new development in general practices is the management of doctors by other clinical professionals. The two partners at NurseLed wanted

employees who were team players and able to work autonomously in a small unit. Two salaried GPs were dismissed, one for being too cautious in approach and the other as not a 'team player'. Two other salaried GPs were supplied by the PCT, both from different EU countries but in the view of the two partners these doctors were not trained in a way suitable for the needs of primary care in the practice and the practice could not afford the time or money to train them. OverThere also line-managed its medical staff. One daily task for Regional Directors of Clinical Operations was to use the morning 'huddle' as an opportunity for looking ahead at individual doctors' schedules and trying to facilitate their smooth running. So, for example, if they had back-to-back physical examinations to perform, which took some time, they were allotted extra time in their schedule to do those. One such manager explained his managerial style as: 'I'm never tough on people, but I'm very tough on practices.' (Regional Director of Regional Clinical Operations of Primary Care, OverThere).

Especially in general practices, coordination of productive work between partners and employees was often achieved through a 'teamwork' (approach, one which was also technically required by the multi-professional, indeed networked, character of the more complex forms of primary care. A team approach to working carried a relatively egalitarian style of coordination from the democratic world of the partners or members into the subjoined hierarchy. Whilst this type of managements appears in hierarchies too (e.g. as 'matrix' management (61)), in the partnerships and small cooperatives we studied such teamwork was the normal mode of working and problem-solving:

In an instance last week … a home visit got missed and anything like that becomes a critical incident and is discussed with everybody in the Team, obviously that sort of incident would involve admin as well as medical staff so we re-wrote the procedure and discussed it with everybody and now it's adopted to try and prevent that sort of incident happening again.

(NP partner, NurseLed)

Exactly the same procedure was followed at the PCT-managed practice when one of the GPs visited the wrong patient at home one evening.

NurseLed receptionists had a separate meeting every week, the nurses met every 6 weeks and the nurse practitioners every month to 6 weeks. Specific issues to those groups are discussed, noted and minuted. There were regular team meetings and, in this small practice, reliance on informal communication. Practice meetings can be regarded as a permanent, routinised teamwork structure. Speaking of other practices she had worked in, an employee at NurseLed told us that, team meetings were often not in fact held, even when practices claimed that they were.

Partnerships outside the health sector also applied a team-work approach. Legal divided its business across a series of teams which covers specific areas of law. Within each team is a series of units based on practice areas (company and commercial, employment, dispute litigation, real estate, advocacy, clinical negligence, family and childcare and private client), each

with its own leader. The architectural partnership also constructed teams for each project (the partnership's market niche was medium-sized schemes) or, sometimes, for a sector (e.g. health, education). Each team combined partners and employees by expertises as the case required and was headed by a director.

9.3.1 Pay

Salary schemes were the other means of incentivising and controlling employees, replicating in two of the partnerships the external incentives to which the partners were exposed.

The PharmPlus staff bonus scheme was an incentive worked through an elaborate weighting of bonuses to reflect individual effort, as assessed by managers, towards meeting QOF targets. This bonus were not guaranteed but contingent upon the whole practice doing well with the QOF. Rewards were based on a grid that measured achievement against each employee's level of effort. The grid was discussed at the Practice Leaders' meeting and the Practice Manager took the results to the partners who could adjust the scores. This was a change from the previous Christmas bonus scheme that had been based purely on length of service which, the partners felt, this did not recognise effort. Similarly, PlusPM employees received a cash bonus if the practice met its QOF targets, the bonus being up to three weeks' pay with a ceiling of £1000 in addition to a Xmas bonus.

HouseLend staff were salaried but all eligible for performance related pay if they hit predefined targets. For branch staff these included, for example, the number of sales leads passed to other departments to allow the closing of sales of financial 'products'. Pay differentials at partner or member level tended to be absent or small compared with the corporate world. The general practices tended to distribute their income pro rata to work contributed (i.e. without differentials except for quantity of work). The recruitment of a pharmacist partner at PharmPlus triggered a debate about about what this new partner was (financially) worth:

I sort of felt that from the business point of view, if you were a director in a company, you had equal worth because you put equal contribution in, despite whether you came from a financial background or a management background, you still had equal worth. So my argument then was, I am equal to you. Their [medical partners'] argument then was ... still they would be holding some accountability for the work I do clinically … So we came to an agreement that I would do, although I am a half time share partner, I would work 5 days a week for a year and I would move to a half time share over three years which was fine.

(Pharmacist partner, PharmPlus)

By the end of the three years all partners received either a full share or a half share, depending on the work contributed to the partnership as a whole. Proportionately to the hours worked, there were therefore no income differentials among the partners arising from the work of the partnership itself. PlusPM practice's operating surplus was divided pro rata to sessions worked except for the manager-partner:

they [GP partners] feel that the value of those ten sessions isn't necessarily as good as me seeing a patient. So we spent a lot of time arguing over that! But effectively I ended up with a 9 to 10% share.

(PM partner, PlusPM)

Metro directors were paid at the same rate as clinician members for the managerial time they spent at the cooperative outside normal working hours. Generous pay increased the pressure to ensure that members working as clinicians pulled their weight:

When 'they were getting, you know, about £20 an hour, then you couldn't be too hard on people if people had a gap between calls and sat down for 10 minutes to watch the telly, then it wasn't a big deal. Now they are on £80 to £100 an hour, 10 minutes watching telly is 15 quid's worth of time that's gone down the tubes. Whilst we have not been too hard on that … we have parted company with a few doctors that were noticeably slow on a regular basis, even when it was busy, and I think word has gone round.

(clinical governance lead, Metro)

With session fees at these rates, City and Metro had surpluses of members volunteering to work. Metro engaged them on what it called a 'practising privileges agreement' so that it paid only national insurance and not tax on their work. In cooperatives and partnerships alike employees of the same profession as the members or partners were an important exception to the rule that employees be paid less than a partner or member:

It's [a GP's salary is] basically keeping in line with what the GP partners get because it seems totally inequitable to pay someone more to do less than you are being paid to do. So we resisted that.

(PM-partner, PlusPM)

Non-health partnerships paid the partners on the basis of judgements against a wide range of criteria such as income generation, maintenance of regular clients, securing new business, overall performance and one's own conduct of work. Legal had introduced a performance-related pay scheme in 2008-2009, but at team rather than individual level. To qualify, all the teams had to meet pre-defined targets. Whilst some teams had exceeded targets, others (e.g. conveyance) had not. Therefore nobody except full equity partners received any monetary bonuses that year.

Wholefood cooperative took a strong line against pay differentials:

Same hourly rate, so there's no, there's no differentials; so it doesn't matter if you're um operating a specialist task that will have a market value greater than the hourly rate... ah, it doesn't matter if you have mild learning difficulties.

(Member, Wholefood)

Probationers received the same rate of pay as full members. Monetary pay was were similar to other shops and cafes in the city but members also received a 25% discount on anything bought from the shop, free food, free complimentary medicines (if stocked in the shop), six weeks' paid holiday and a month's sabbatical after five years. Non-financial rewards also loomed large, such as being able to support other like-minded organisations. The

constitution of Bigshop stipulated that neither the Chairman's own income from the Partnership nor the income awarded to anyone else may exceed a certain upward limit. Neither can any member be paid less than a lower wage limit fixed by a Council. To that basic wage was added a family allowance (fixed in the same way) for any dependants. All the dividends were also limited to a fixed rate. The large retail cooperative had substantial wage differentials, but less than corporations in that sector.

9.4 Degeneration and managers

Only our informants in the mutuals and cooperatives raised the question of degeneration. The question arose more sharply in the two retail cooperatives, the mutual building society and the health consumer cooperative than in the two out-of-hours cooperatives which had explicitly adopted a general-practice like structure. Ways in which, we were told, democratic control by the members might degenerate were through the growth of managerial discretion; the 'managerialisation' of the senior staff employed as stewards of the members' interests; and the decline of member engagement.

9.4.1 Managerial discretion

At the interface between members and employees, an important 'window' for managerial discretion emerged in three circumstances.

The first was when an organisation accommodates apparently conflicting interests, in the case of a building society those of borrower-members and those of lender-members. How to balance these interests was a potentially delicate, ambivalent matter which gave senior managers the opportunity to exercise their own judgement and discretion:

It's very clear that the Board has to act in the interests of the membership as a whole, both current and future. So in effect we are Trustees of the mutual organisation and we do have to take primarily the Society as a whole. So we can't differentiate between borrowers at the expense of savers, or savers at the expense of borrowers... So if we felt we [organisation] were doing something which was not in the interests of the Society of the future we [managers] can dismiss it.

(CEO, HouseLend)

By far the most important exercise of this discretion came when it was proposed to convert this mutual building society into a commercial bank.

During the recent US health policy about the proposals for a single-payer health system, OverThere also accommodated conflicting interests, those of insurer and provider. Although OverThere's founding values might have been expected to support a single payer system, the managers steered the organisation away from publicly advocating that view. When members' interests' potentially clash with those of OverThere as an organisation (as our informant rather tendentiously put it) the governance staff discourage groups like the Senior Caucus (particularly by chair and vice chair) from

opposing what the managers recommend on behalf of the whole organisation. In the single payer healthcare system debate, as the Senior Caucus vice chair put it, 'It's important that we don't stray off the reservation and get into things that are not good for OverThere.' Here, the 'organisation' appeared to have acquired interests distinct from those of its members; apparently the interests of its managers and employees.

Ill-defined divisions of labour between members (or their Board) and managers also create space for managerial discretion and autonomy. In OverThere the most stark example was a proposed merger with Kaiser Permanente. The Board Chair said she was informed only when the talks with Kaiser were far advanced:

There was a final decision and the decision to have that agreement between organisations had to be signed by the board chair, who was me. I remember me ask[ing], "Would you come down and talk?" We talked about it in the board and pretty much said "Yeah, I guess we'd better do that, there's not much else".

(Former Board Chair, OverThere)

The Chair of one medical council explained to us how in one locality OverThere decided to withdraw their services from one hospital and contract instead with the Franciscan hospital. The local MCAC was outraged 'there was the question of whether of not they wanted to contract with a Catholic hospital with its different attitude towards end of life issues and abortion (assisted suicide is legal in the state, following years of campaigning). OverThere did not consult the local MCAC before making their decision. The chair complained, was told it would never happen again and everything was smoothed over. There was a balance to be kept between facilitating the meetings, putting together the agenda and 'setting' the agenda, which members assure us the governance managers from OverThere do not do.

HouseLend employed managers also deflected a far-reaching decisions which at least some members appeared to prefer. Each respondent individually and without prompting referred to a call by members about ten years before to allow a vote at the AGM to de-mutualise the society. A single member was able to bring this fundamental decision to the Society's AGM. However the apparent decision-making power which this gave members was severely qualified by a legal restriction which the managers exploited:

in fact...all you [members] can do is you can get the Board to consider doing something - there's this great case law on this 'so [in] that instance the best that the members could do was put forward a resolution that said: "We recommend the Board consider conversion' So that went before the membership and there was a vote and it was 95% in favour because all they were doing was asking the Board to consider something that we already do anyway, so the Board followed the instruction, considered it and dismissed it.

(CEO, HouseLend)

Subsequently discussion of this question became routinised:

on an annual basis, [we] consider our status and it only takes a few seconds to do that because the demutualisation experiment over the last few years has been an unmitigated disaster.

(CEO, HouseLend)

Important as it was, the proposal to demutualise was the only example in recent years of resolutions coming from members. Mostly resolutions came from the board, and many concerned relative technicalities such as the noting the adoption of the accounts. Some important decisions never went to the AGM:

We don't put any of our investment decisions to members. So that's in terms of the subsidiaries, even at Society level in terms of products we don't put any resolutions.

(CEO, HouseLend)

9.4.2 Managerialisation

In the largest study organisations, our informants wondered whether increased in organisational size and the increased managerialisation of the employed staff would compromise members' governance over the organisation.

OverThere's employed managers had become considerably more 'managerialised' in recent years. The calibre of the Executive Leadership Team had increased, partly because the pay had increased. The Board's compensation committee voted for the increase but some leading members expressed strong opposition, for instance dismissing the managers' arguments for raising their own pay as 'Self-serving bullshit' One of our informants feared that debate would become inhibited; how were members going to be able to engage in debate with a management which can 'run rings' round them? On the managers' side, a governance executive remarked:

If you were to go back several years, these folks [member chairing the medical centre councils] used to make important decisions about their facilities.. As we have evolved as an organisation, these have had less and less power. And that has been a source of frustration for some of these folks actually, where they would like to be able to call up or CEO and have a great conversation; some of them still can, but it's a much smaller group.

(Manager, OverThere)

Members were entitled to meet, if they wished, without any staff present. However,

the staff wish to attend members' meetings because

they 'want to make sure that there is no inadvertent effort or inadvertent course of action taken that can be harmful to OverThere.

(Member, OverThere)

One consequence of recruiting supposedly more skilled, ex-corporate managers was to import with them assumptions and working practices which included some apparently inconsistent with, indeed damaging to, the goals and founding principles of the importing organisation.

9.4.3 Member engagement

Organisational structures for member engagement in the study organisations' affairs are described above. Some OverThere members felt that the low level of member participation meant the organisation was in decline as a cooperative or a cooperative only in name. OverThere Members were suspicious of managerial ideologies, symbolised by such terms as 'lean management', or 'customer' instead of 'member'. One member described a 'vicious circle' between the passivity and lack of active engagement by the consumers partly arising from the lack of control they feel over OverThere business and the fact that the employed managers actively set the agendas. A former chair of a members' group however disagreed. She argued that the 'natural evolution' of the cooperative into a large organisation does not signal such decline, only a change:

I don't despair of the fact that we don't have big meetings of the whole thirty thousand or six or three hundred thousand elected members every time we want to make a decision, because it wouldn't work. The only question is, is the elected board providing sufficient oversight in the interest of the membership over this corporate process, because the corporate process is a powerful dynamic process and it can very easily co-opt 'the co-operative governance process.

(Member, OverThere)

In a similar situation the chief executive at HouseLend thought the opposite:

In terms of actual attendance at the AGM it's literally just a few dozen. I mean there can be more staff members.

(CEO, HouseLend)

We asked 'So what do you see as the role of the Annual General Meeting?'. He replied: 'A statutory function'.

9.4.4 Size and risk

The question of whether growth made NHOs unsustainable was also raised by an informant from our building society site:

out of all the converters [from building society to corporation] the one that I believe had a business rationale to do it, and the only one, was Halifax because it had 22% of the retail market, 25% of the mortgage market. They were competing against the major high street banks and international banks coming to the UK and they were so big 'So it was probably purely as a result of their size that I believe they had a business case to convert, so they had access to the equity markets because it was right that the shareholders took that downside risk and not the members.

(CEO, HouseLend)

One the one hand this argument shows concern for the members' financial security, but it also reveals and assumption that if building societies were to compete with corporate banks they (would have to operate in equally risky ways.

The question of degeneration arose acutely only in OverThere. The smaller food cooperative had a constitution designed to prevent a permanent

managerial stratum emerging in the first place (through direct democracy and the rotation of managerial posts). The larger food cooperative's members were organised into a managerial hierarchy, but the rights of its managers were ultimately circumscribed by legally-binding documents of foundation and the cooperative's constitution. These documents both gave the managers a wide field for discretion but also defined its limits, closing off the scope for discretionary managerial encroachment on members' decision-making powers.

9.5 Professionals in non-hierarchical organisations

Of our study sites, the large retail cooperative had (only a small proportion of professional members and the small retail cooperative none. In the building society a substantial proportion of staff had some sort of professional qualification, but they were employees not members or partners.

9.5.1 Multi-professional partnerships

Two of the study general practices had non-medical partners, one (PharmPlus) a pharmacist and another (PlusPM) a manager. Recruitment of partners of a different profession to the existing partners happened as an ad hoc problem-solving measure, partly stimulated by external policy changes. Had this study occurred two years later, we could also have observed in other legal partnership (Legal) the effects of changed occupational mix of the partners at this site when the Legal Services Act comes info force in 2011.

Recruitment of the pharmacist partner at PharmPlus occurred by almost by trail-and-error. Initially one of the medical partners had a watching brief for the pharmacy but found it too much work to an add on to a GP's normal work. Because of the new GMS contract and QOF the GPs were by now looking at new organisational models for the practice anyway because work was 'mushrooming'. Through their involvement at their PCT two of the GP partners knew the prescribing lead and approached her to 'work with' the practice, having no initial preconceptions exactly how. The pharmacist partner developed a case-management role similar to a GP's, beginning prescribing as a supplementary prescriber within case management plans agreed with the GPs. However it was she who wrote these plans for angina, heart failure, diabetes, ischaemic heart disease, epilepsy, hypertension and hyperthyroidism. This activity caused the GPs to compare their clinical practices with hers, finding that some of their clinical practices were habitual rather than evidence-based. In order for the pharmacist to act as a supplementary prescriber the GPs had to homogenise their clinical practice. This clinical role was not without its initial difficulties for both the pharmacist and the GPs, who found the idea of her seeing and managing patients 'a challenge' to start with. On her side, the pharmacist found it challenging to deal with the more clinically complex patients; patients

wanting to widen the consultation ('while I'm here...'); and some of the complications and implications posed by some patients' (social backgrounds. The pharmacist preferred to have partner status and none of the GPs had any difficulty accepting that. Her partnership agreement was on the same basis as the GPs', sharing all the risk and all the profits, and acquiring an equivalent fund for PGEA training to what a GP partner would have and a share of the PLC attached to partnership proportionate to her share in the partnership itself. Other informants agreed with her own assessment that;

Here I am recognised just as another clinician, another health care professional, so I work very much, you know, with the clinical team on my day to day role, but I have the business interest to maximise the profitability of the dispensary, because I have an expertise in that area so the partners see that as a key role.

(Pharmacist partner, PharmPlus)

Her eventual incorporation as a partner took about three years.

In PlusPM the practice manager was elevated to partnership. The GP partners regarded the practice manager as good as his jobs and wanted to be sure to retain ('tie') him to the practice. The partners had noticed a nearby practice considering the same step to retain a very competent nurse practitioner. The practice manager already received a profit-share so moving to become a partner was a relatively small step in terms of role, although it increased his income. We were told it made little difference to his participation in running the practice either:

he has always had as much say as us anyway. We are fairly egalitarian that way anyway. We are quite happy to be guided by him.

(GP, PlusPM)

With a managerial, in contrast to a non-medical clinician, partner there was well defined division of labour with few overlapping elements in different partners' jurisdictions.

9.5.2 Salaried and partner professionals

Our study general practices had partners and employees of the same profession; nurses at NurseLed, doctors at PlusPM and PharmPlus.

All the study health partnerships had hesitations about employing salaried GPs, but for different reasons. PharmPlus partners felt that partner status made them collectively responsible for the work of the partnership, even if this meant working longer hours than if they had been salaried workers. It reinforced the incentive for each partner to check that others were also contributing their share of production and management work (mutual scrutiny). They did not wish to weaken these incentives. Also the shared benefit of having a salaried GP implied a shared responsibility for managing her.

Partners at PlusPM felt a partners would stay long-term with the practice. They disliked the idea of the

controlling partners or controlling [supermarket chain], employing lots of salaried doctors who will come in and do their shift and collect their money and go and not be part of the business.

(GP partner, PlusPM)

For salaried doctors at this practice it was specified what hours they would work, how many patients they would see, what visits and paperwork to do, and what time was protected for teaching and personal development. Thus the salaried doctor's contract was basically the same as for other employees but with dedicated training time. The practice also recruited a salaried registrar. Without the salaried doctors' workload being specified in advance

you thought well, we are actually not going to get any work out of this person.

(GP partner, PlusPM)

Nevertheless this GP also said that with the salaried doctor currently employed in the practice

our problem with [name] is not that she doesn't work hard, it's stopping her working. She does work very hard and we are telling her, for God's sake go home and switch off.

(GP, PlusPM)

NurseLed was wary of employing salaried doctors for a different reason. The partners asked 'why pay them [doctor] that big salary to do something that somebody on a lower salary can do?' (Nurse partner, NurseLed). The policy for medical recruitment in that nurse-led practice was that any salaried doctor had to be able to work independently from the outset without a high level of support, which was not available in a relatively small, newly re-founded practice. The best way to recruit a doctor, in the view of NurseLed partners, was by recruiting one who had proved satisfactory as a locum. The main difference between the employing partners' and employed nurses' role was that the former undertook wide-ranging, inter-professional management work in addition to their clinical work and leadership. The line management of one nurse by another is however such a long-established practice that our informants regarded the arrangements at NurseLed as unproblematic, barely worthy of comment.

At PCTrun, where all doctors were salaried, they were annually reviewed by another GP external to the practice. Although his practice employed a salaried GP, one of our informants was sceptical of the value of salaried general practice elsewhere:

PCTs will always tell us to follow national guidance. They always follow national guidance which is why PCTs' PMS practices don't hit any of their targets, certainly in [town]. The three practices that so far under-achieve consistently, are theirs.

(PM-manager, PlusPM)

If this be true, the under-performance might conceivably arise either for the reason this informant stated or because PCTs often tend to take over (and convert to salaried general practice) small, marginal or struggling practices.

The out-of-hours cooperatives paid members a sessional rate for working shifts. Salaried GPs were disproportionately represented among City's working members: 'quite a few salaried doctors also work here. ' they want quick money' (CEO, City). But so far as the cooperatives were concerned there was no difference between members who were the salaried employees of practices and those who were practice partners.

OverThere's professionals were its employees (or in some cases sub-contractors), not members or partners. Its employed doctors described a democratic way of working, believing that their feedback was regarded as important. Nevertheless there was a clearly hierarchical organisation of doctors. Every doctor had three year probationary period before they were elected into the organisation. A key part of this passing the probation and becoming a 'Shareholder'was, the medical director of primary care explained, that they received high patient satisfaction scores.

9.6 Professional engagement

9.6.1 Engagement within organisation

Comparing our study sites, the engagement of members in general (irrespective of occupation) appeared to depend upon:

1. What other commitments members had, hence the relative importance of the organisation's activity in its members' lives. Consequently members' engagement in provider NHOs was higher than in consumer NHOs. For GP members, participation in the governance of cooperatives was usually one of the less pressing demands on busy working lives.
2. Members' geographical dispersal (building society members) or concentration (GPs in cooperatives).

Rather like Arnstein's 'ladder' of citizen participation in civil society (343), our data suggested a hierarchy of engagement in cooperatives, ranging from payment of subscription and use of the services only (to volunteering do paid working sessions to unpaid participation, for instance in the managing bodies.

Without ranking the following factors, it appeared that among professionals specifically, engagement appeared to depend upon:

1. Co-ownership of the partnership or cooperative, which provided both the means and the incentive for engagement in its management. For non-partners the possibility of future engagement as a partner provided an incentive to work well and to maintain good working relationship with existing partners. We were told of this phenomenon in both an NHS (PharmPlus) and the legal partnership (Legal).
2. Material benefits. Similarly the connection between engagement and payment was much closer in partnerships than

cooperatives, but even so both cooperatives attracted the participation of members as shiftworkers simply by paying them generously. City retained membership by providing incentives for GPs to remain opted-in to providing OOH cover and then doing so via City. These incentives included a free locum service (GPs opted-out from OOH had to pay for locums) and an answering service free of charge because of economies of scale, gave this additional service a negligible marginal cost. Only members could do paid work for the cooperative, thereby recouping some of (or in a few cases more than) the cost of membership.

3. Experience of the practical usefulness of the organisation to them. This applied even in the ex-cooperative that later converted to a PLC. Originally

'it was a little bit marginal really in terms of numbers and compared to lots of GP co-ops, we could only just about make it work, but it did work very well and within a couple of years, 'three years, the [town] GPs could see that it was a better way of working and that it was safe in terms of patient care.

(GP co-director, WasCoop)

4. Even if the NHO or partnership was (marginal to (a professional's working life its decisions might have practical implications for her more central activities and interests. For example it was a matter of some interest even to the less active GPs members of Metro and City whether these two cooperatives got involved in practice based commissioning, began operating diurnal services (which the GPs were already doing themselves), took over vacant local general practices or set up a 'Darzi clinic'. In these periods professionals became more actively engaged.
5. Open access to board members appeared to promote clinician engagement:

most of the people on the council are the doctors themselves, so they are elected partly from the body of doctors and sometimes the doctors go directly to the council members to say, "What's going on here?" or "This is what I think".

(Finance Director, City)

Similarly in OverThere, by far the largest employer of clinicians in the study, informal access and feedback to higher managers was used to promote clinician engagement, particularly when it came to pilots for new models of service models. Each clinic started the day with a 'huddle' at which staff and doctors discussed particular issues (e.g. pharmacy initiatives) and anticipated problems (e.g. scheduling at the clinic, shortage of appointments). Twice a month there was also an one tour provider staff meeting looking at issues specifically relating to the clinic.

6. How far they subscribed to the culture and goals of the organisation itself. This emerged more clearly from the US case

study than the more homogeneous NHS. One interviewee, a primary care doctor called his clinic:

certainly by far and away the best practice I've been in. I feel I can do the right things for the patients without killing myself in the process 'my worst day here at [OverThere] is better than 90% of my days at Kaiser.

(Doctor, OverThere)

We found little evidence of professionals' disengagement or resistance. Whilst the PCTrun doctors had sought salaried employment because they wanted to disengage from managerial work, that did not mean they resisted managerial decisions or power or refused to contribute, only that they wanted more time for clinical activities.

With a view to testing the predictions (see above) about the degeneration of co-operatives we researched a former out-of-hours cooperative which had converted itself into a commercial firm. Implicitly this conversion increased the engagement of some professionals (the new owners) and reduced the engagement of others (former members whose role was now restricted to that of employee or sessional sub-contractor). It turned out that the reasons for the demise of this cooperative lay in the disorganisation of out-of-hours services across the local PCT, a problem exposed when the 2004 GMS contract permitted GPs to opt out of providing out-of-hours services:

Leading up then to the October 2004 opt out the PCT began to hold various steering groups and ... I think [PCT name] was somewhat unusual in that it was in complete disarray. I think I am right in saying it had 14 different out-of-hours providers at that stage, and we were easily the biggest. And that ranged from a single-handed guy doing it by himself to bigger practices or whatever. But it was a mess. … (And at the end of all these meetings … I went up to one of the managers there who was running it and said, "I don't think we are going to get anywhere. Are you interested in me and perhaps one or two colleagues coming up with a vision, a plan of how we might run the out-of-hours service?".

(Director, WasCoop)

The figure of 14 providers turned out to be only for a part of this PCT's territory. This co-operative thus fell victim not to its own inefficiencies, asset withdrawal or 'free riding' but rather to a 'garbage can' (344) style of commissioner management.

9.6.2 Engagement in health system management outside the organisation

External networking with similar organisations was a way of giving and obtaining mutual support and encouragement, and the same pattern appeared outside the health sector. HouseLend was one of currently 55 building societies who kept in close touch 'on a whole host of issues apart from commercially sensitive [ones] in terms of product design etc,'. (CEO, HouseLend), in part because:

we do recognise the fact that as a sector we are probably less than 20% and we're up against major high street players, [and] we're now up against Her Majesty's Government who will end up being the largest mortgage lender in the UK.

(CEO HouseLend)

Our Wholefood informant involved with food-growing stated that food growers like to work with them because they are ethical 'unlike supermarkets' who (he said) often exploited their suppliers in ways he described.

A wider range of professional contacts was specifically mentioned as a benefit of working for an OOH cooperative:

It's one of the main opportunities that a lot of doctors have to stay in contact with other doctors 'finding yourself working a shift with somebody who might have been working two miles up the road for the past 10 years, and you didn't even know what they looked like.

(clinical governance lead, Metro)

However, we were also told that this benefit becomes diminishes once the NHO grows beyond the size of what might be called a 'natural community' of doctors, for instance those working in one town or for the same PCT.

As for PCT-level work:

Interviewer: 'What do you actually get from them, these bodies? What do you provide in return?'

GP: 'From the PCT?! (laughter). Forms to fill in, hoops to jump through, targets to hit which are, you kind of wonder, what's the point of these targets, but, you know, not a great deal. We are mainly pretty independent and we 'yes, we get guidance on this and guidance on that, you know, clinical guidance is useful. We do get some support from the PCT when - there will be times when we feel that some demands of some patients are not reasonable with regard to prescribing.

(GP, PlusPM)

Consequently PlusPM's main external networks were with the other practices in its local PBC consortium.

In the sites we studied practice based commissioning was noticeable more by its absence than as a means of professional engagement with NHS management. (Other studies have also reported the uneven development of practice based commissioning (345,346,8).) Whatever practice based commissioning offered by way of professional engagement in management, it also incurred transaction costs of collecting data and de-duplicating secondary providers' invoices. One partnership was overtly sceptical:

I am very anti. If the PCT can't commission, how the hell are smaller organisations going to be able to do so? It's nonsensical.

(manager-partner, PlusPM)

Engagement (or not) thus depended in part on the professionals' perception of how coherent and how practically helpful to them a given policy was likely to be. The case studies show two main structural for organisational democracy in partnerships and provider NHOs: direct democracy within small work-teams; and what we called a 'representative' structure where working conditions necessitated a more extrinsic discipline. Voting and participation rights within partnerships were based on property-

qualifications, though less so in health partnerships than elsewhere. NHOs had egalitarian voting and participation rights among their members (if not for employees). Management was primarily through concertive control, supplemented with exit in exceptional cases. Pay differentials among members or partners were low. Professional engagement depended mainly upon the material and practical benefits thereof, and upon whether professionals found the organisational culture congenial. In partnerships, ownership and control were the main basis of professional engagement. Only small minorities of members engaged actively in the consumer NHOs. There, employed managers influenced the election of officials and took most decisions.

10 Process: case study findings

Next we report the case study findings about the technical, productive processes by which the study organisations attempted to realise the goals reported above.

10.1 Impact on workloads, job satisfaction and morale

We found some evidence that members or partners of NHOs would select (if they could) a workload focusing on occupationally highly-esteemed types of work, dropping lower-status work or, in partnerships, transferring it to non-partners. Such transfers were constrained by the legal regulation governing the division of clinical labour. This especially affected NurseLed since English regulations constrain nurse practitioners' work (more narrowly than general medical practitioners'. Comparing doctor-led and nurse-led practices, we found in both (that the partners tended to raise – so far as practicable - the skill level of their own clinical work and transfer the residue to employees. Both the upper and the lower skill thresholds for the partners' work were thus raised. This permitted job enrichment for the employees too.

Recruitment of partners from non-medical clinical professions had a similar effect. PharmPlus's pharmacist partner persuaded the GPs to support a different role for the pharmacy than they had first envisaged:

I think their view 'was the traditional view where you go now to health centres and there's a Lloyd's attached to it, they were still separate businesses. ' What I saw was ' we could get the pharmacy to actually do those services, public health services, so this would take on a lot of the roles that the practice nurses do 'Then we could also use our nurse practitioners more in terms of minor ailments, which we [in pharmacy] currently do, which means a pharmacist might be freed up to do domiciliary visits for elderly ill, and look at medicines reviews.

(Pharmacist partner, PharmPlus)

So the pharmacy assistants would take on some former nursing tasks, whilst nurse practitioners took on some former medical tasks, as would the pharmacist partner, who also became a clinician in her own right as described above. Partners at the nurse led practice (NurseLed) reversed its division of labour from that in a conventional general medical partnership to one in which nurse practitioners replaced GPs as the point of first contact and the overall case-manager for patients. Nurse practitioners became the first point of contact for patients, with the goal that 60% to 70% (acute basic care; long-term chronic disease monitoring; well people screening) would be treated entirely by a nurse practitioner. Very sick people with complex conditions were referred to a doctor. By a different route the outcome was similar to that in PharmPlus. GPs increasingly concentrated on more complex cases whilst NPs undertook general consultations.

PlusPM GPs wanted more control over care, distrusting the trend that:

Telephone consultations have become a lot more common but I know there is an awful lot of practices where the patients phone up and talk to the receptionist and get antibiotics, they never ever speak to a doctor.

(GP PlusPMs)

Even so, certain clinical roles still transferred to nurses:

We [GPs] used to be going in every day or every other day to people terminally. Now it's the Macmillan Nurse who will be going in and then feeding back to us, which in a way I regret because it was one of the most satisfying parts of general practice. But things move on.

(GP, PlusPM.)

Both the OOH co-ops allocated medical shifts by rotation among those who had applied (volunteered) for that particular shift. Other work was undertaken by paid employees, mirroring the division of labour in a conventional general practice. Here too staff of other occupations were taking on the more routine aspects of doctoring. For example if a lot of patients arrived at the Primary Care Centre and nurse practitioners in triage were not busy they were expected to see primary care centre patients; and when the treatment doctors had little work they undertook telephone triage.

OverThere discovered that by removing unnecessary or stressful work, good quality support systems also improved doctors' job satisfaction. The way OverThere operated from the mid '0s to about 2000 gave them a poor reputation and affected doctors' morale considerably. One doctor who experienced this phase in the organisation's history said:

I was ready to quit, honestly, you know, about six or seven years ago...the systems were poor, the systems were discordant... you work as hard as you can and neither are you good for the patient nor good for the administration... ([patients] couldn't get in at a reasonable time, schedules were overloaded. They would come in; we wouldn't have the chart available … very inefficient, and then we would refer to the specialist.. the specialist would say they didn't get any records, they would say "Why are you here?" and the patient would say "I don't know, they told me to come over here".

(Doctor, OverThere)

Two innovations which improved the situation were the changes to Electronic Medical Records (EMR) and to the primary-care led 'Medical Home Model'. The latter, a more primary care centred model of care, was credited with markedly improving doctors' working conditions and hence job satisfaction. It reduced patient list size from 2500 to 1800 per doctor, and that rather than any financial reward was their incentive to adopt it. As one doctor described it:

"See you guys, I'm going home at five-thirty and I don't do emails in the middle of the night." That's an enviable position for a lot of people.'

The two retailing cooperatives took opposite approaches to allocating members' work. At Wholefood all members eventually did all jobs:

We are a multi-task organisation and also a consensus organisation. Tthere isn't an individual who pays accounts thirty-five hours a week and then goes home, and there isn't an individual who cleans the toilets thirty-five hours a week '[This arrangement] develops understanding

and diversion, range of skills and also empathy. If you have spent time in the packing, trying to reduce bags, you can understand what's going wrong there.

(Member, Wholefood)

Each working team had a specific function (e.g. personnel, operational planning, training, store), and the cooperative was thus moving away from having the individual to having the work team as the basic organisational unit. In the larger cooperative there was in contrast a stable division of labour with a corresponding gradation of pay and authority. This large cooperative contained almost no non-members, so an allocation of high-status work to members and lower status work to non-members could hardly arise. Neither was it technically practicable for members to abandon the more onerous types of work.

As noted, the architectural partnership recruited employees to do the types of work that the partners felt uninterested or not competent in. For architectural work itself, the partners organised themselves by the stages of the core process for an architectural project (inception, conception, design, production, delivery) but also required a lead to coordinate the project and present it to the client in a coherent, unified way. Division of labour was by legal specialisation in the law partnership. Individual solicitors 'there were few other occupational groups 'were allocated to specialty teams which were not location-specific but dispersed across four towns and cities regional-wide. There was a clear division of labour between legal professionals and non-professionals, and within the legal profession the gradation of ranks described above.

Pay, pay differentials and their part in the management of the study organisations are reported above.

10.2 Economies of scale

Economies of scale were apparent both in the partnerships and the cooperatives. The former was a somewhat unexpected finding because the partnerships were relatively small organisations with essentially handicraft core processes of the kind which resist mechanisation, the usual source of economies of scale elsewhere. It was less surprising that the OOH cooperatives, with their more standardised, larger scale, more automatable core processes (call-handling, vehicle scheduling) displayed economies of scale.

Metro informants also described economies of scale (and diseconomies of scale from losing contracts: see above):

You need at least 300,000, actually to be precise 285,000 members of the public, to be able to provide this [service] effectively. ' you would need to place one GP at least [for] '24 hours coverage 'at least one supervisor, at least one driver 'then I'd say, 'How much would this cost to me?'and look at the minimum rent or whatever and say, 'How much would that cost to me?" so we are charging £3 per list size [i.e. per listed patient], how many people do we require? And that's where I get those figures.

(CEO, City)

Also City bought supplies such as gloves and flu vaccine in bulk, passing the savings on its members.

Both the partnerships and the cooperatives were able (start-up finance permitting) to launch a virtuous circle of expanding services, expansion reducing unit costs, making more price-competitive bids for work (enabled by lower unit costs), leading to further expansion. Loss of a contract started the reverse vicious circle for (in this study) Metro. In these respects NHOs appeared little different from corporations.

10.3 Capital

Given these economies of scale, the expansion of the general practices, and the large-scale out-of-hours cooperatives, required funding to replace and upgrade buildings and equipment. The study organisations found the short-term cost-covering constraint particularly restrictive when it came to the start-up costs of large changes to services.

PlusPM practice had planning permission to extend for some years, but no way of raising the capital from its own retained earnings to do so. PharmPlus practice found the obvious alternative, the Private Finance Initiative (PFI), equally unsatisfactory; disadvantageous to the practice because a PFI contract would lock the practice into renting the building from (external) private developers for 35 years. (LIFT did not have this drawback.) NurseLed's parent organisation was unable to supply capital investment because the short duration PCT contracts made the investment too risky. From a different standpoint the architectural partnership had also experienced of PFI, finding that because the scheme multiplied the number of agents and organisations involved in capital projects, making it harder for the architects to know who precisely was the client among the many interested parties.

Whilst the partnership model and cooperative models made it hard for some of the study organisations to access capital from the financial services sector, that turned out a blessing in disguise when the financial crisis (of 2007-2008 occurred because, being entirely member-owned they were insulated from these vicissitudes. In contrast these events also caused financing difficulties and retrenchment for one the three commercial firms whose CEO we interviewed.

Outside the health sector, for HouseLend the significance of generating a surplus was that:

we can't subscribe for share capital, we can go to the capital markets to raise debt but they're closed at the moment [2009], but even then we're restricted in terms of how much, so we are highly dependent [for development] on organic generation of profits after tax.

(CEO, HouseLend)

The only organisation which reported any distinctive approach to raising and using capital was the small retail cooperative. Wholefood pursued vertical integration by starting to grow food necessitating a land purchase costing £150,000, a significant step for the cooperative. It was funded by customers' loans, at an interest of rate of their choice, in fact between 0% and 6%. Lenders did not become shareholders or gain any decision-making voice in the cooperative. One of the cooperative's goals was to provide long-term secure work for their members. They were therefore risk-averse about over-extending themselves financially.

10.4 Patterns of innovation

We observed five patterns of service development in the study sites: extensive development (replication); vertical integration; diversification; re-configuration of an existing core process, at times involving an intensification of the services given; and responses to external requirements. Only to varying extents were these changes 'innovative' in the sense of introducing new techniques for carrying out existing core processes, although they were more 'innovative' in terms of changing the models of service provided by the study organisations.

10.4.1 Extensive development

Partnerships developed their core productive activity partly by replication i.e. doing the same activities on a larger scale when local demography and 'market' permitted, recruiting more partners as necessary. This could be done either of two ways. PharmPlus's tactic was to expand its practice list first by acquiring a vacant practice nearby. Such decisions turned partly on consideration of whether economies of scale could be achieved by using the main practice's existing staff to provide the additional service. PlusPM tactic was first to recruit a new partner and then open its lists to more patients. Having female doctors in an area without many others also helped. A larger practice increased patient choice by enabling patients to

gravitate to the partner they prefer because there is always going to be a bit of difference between how we [GPs] deal with people.

(GP, PlusPM)

NurseLed replicated its services simply by employing more nurses (who were the core workforce in this nurse-led practice). The partners anticipated that due to growth of their patient list they would anyway have to move to bigger premises and so planned to use this event as an opportunity to take over other lists and run more surgeries, although their bids to do so had not yet succeeded at the time of writing.

Using extensive replication to exploit economies of scale was a common pattern across all sites, including the OOH cooperatives (see below). To the extent that it stemmed from indivisibilities in buildings and equipment, and

in small organisations of staffing, this pattern of expansion did not much differ from the responses to be expected of a corporation.

10.4.2 Diversification

In the short term the scale of income which the OOH cooperatives could obtain from PCT contracts had a fairly rigid upper limit. The cooperatives therefore exploited economies of scale by adding related services (diversification), either for their members or for third-party customers, to their original core activities rather than expand by replication.

City pursued diversification in order to reduce the risk of fluctuations in membership and income as the terms of GP contracts and PCT commissioning changed. City therefore:

had a huge call centre 'primary care locum services, 24 hour answering services, 24 hour on call services, forensic medical examiners, free education programme for GP Registrars as well as GPs, half day cover for practices when they were closed.

(CEO, City)

The cooperative to exploit economies of scale in these resources:

As we have got resources here ready we have had to do other things so that it is not dormant during the day ' We've got the space, we've got the cars, we've got resources, just waiting to be used.

(Finance officer, City)

This cooperative extended its telephone triage service to cover dentistry, employing a dental triage nurse who could refer patients to local dental practices with out-of-hours services rather than the dental hospital. It arranged for a GP to work in a local A&E department to deal with primary care cases there and bid successfully to set up a Darzi 'polyclinic'. These last two extended its case-load and marked a greater commitment to providing diurnal services, but especially for patients not registered with a GP, which mitigated the problem of potentially competing with its members' practices. The conurbation served was anyway under-doctored.

For Metro, the risks which diversification would mitigate were realised during our study. In October 2008 Metro lost, at least for the next 3 years, their largest contract to provide OOH services. Metro were therefore forced to start looking for other avenues of work. At the time of writing they were undertaking a pilot exercise with practice based commissioning consortia, the PCT and hospital trust to provide supported discharge, urgent care and early intervention services. Metro were also setting up a community IV service to reduce the occupancy of hospital beds by patients admitted just for daily IV treatment.

10.4.3 Vertical integration

To varying extents the general practices studied also attempted vertical integration, especially 'down-stream' by providing 'follow-up' services previously delivered by non-medical primary care (e.g. pharmacy, health education).

When the local pharmacist retired PharmPlus practice took over his business, as described above. This revealed the pharmacy to be an important income stream, enabling the practice to employ more clinicians.

OverThere also attempted 'up-stream' vertical integration, wishing to develop preventive health services for the dual reasons of improving patients' health and of containing costs. Thus, for their medical home model:

If you let people go without their diabetic retinal eye scan, or foot exam.. you know, they're gonna end up in urgent care 'We need to take care of our patients so they don't get sick. So they don't cost us money. So we can go hire more doctors to manage them.

(Manager, OverThere)

In one sense OverThere also pursued vertical dis-integration by remedying the lack, in the US health system, of primary care gate-keeping to secondary care. OverThere introduced gate-keeping by primary care doctors, which required instituting a clear division of labour and better-defined referral criteria between primary and secondary care, and what they called a 'medical home model', basically similar to the English 'closer to home' model in that family doctors coordinated as much of the patient's care as possible.

Outside the health sector, both the retail cooperatives added re-packaging, limited manufacturing activities, gardening and farming (although for the larger cooperative this remained a small proportion of its activity). Smaller subsidiary organisations, also non-hierarchical (one unmixed, one hybrid), were set up to undertake these secondary production operations.

10.4.4 Re-modelled core processes

In provider NHOs, members were the obvious sources of ideas for innovation, but employees also contributed innovations, partly as means of problem-solving. PharmPlus reception staff developed a self-referral system for patients. Letters were sent on patients, 30th, 40th and 50th birthdays with a piece of string for them to check waist circumference and a request to make an appointment if the string did not meet. During the time of the study the practice added an 'MOT bay' for patients to check their own weight, height and blood pressure; nurse clinics to deal with expanding workloads for the management of asthma, diabetes and COPD; Well Person clinics at which cervical smears could be taken and a teenage clinic dealing inter alia with contraception. NurseLed's partners paid attention to recruiting competent receptionists:

if we've not got good receptionists the systems aren't going to work, your basic patient perception will be bad.

(NP partner, NurseLed)

Some changes were made with the intention of improving quality of working life for partners and staff. Such were PharmPlus's new building and PlusPM's attempt to make its office routines 'paper light'. In that practice, the extra income from the new GMS contracts was used to reduce the full-time partners' working time rather than to increase practice activity:

The new GMS contract, yes we earned significantly more money 'but we were all feeling pretty raw so at that stage, I used to work night sessions but the Thursday, which was my half-day, was never ever a half day so [another partner GP] and I made conscious decisions 'that instead of taking all the money, we would take some time back 'and we used some of that [money] to help pay to take on [name] who is also 'full time at our practice.

(GP, PlusPM)

The large retail cooperative explicitly encouraged staff discretion. Twenty to twenty-five years ago the cooperative had begun to develop rules and regulations and standard operating procedures, but it became apparent that too much emphasis was being put upon these. Today, the focus has shifted away from these procedural approaches, so 'releasing the potential of our people', allowing, once trained, staff to make their own judgements within the principles.

In summary, the study organisations selected innovations which reduced reduced labour inputs but not necessarily non-labour costs, which exploited economies of scale and reduced the risks of reliance on a small number of sources of contractual income. We found no instances of partnerships adopting innovations which transferred control of the core productive processes to other occupations than the partners' nor which reduced partners' surplus. We found one instance (only) of a cooperative making an innovation which improved quality of care even though it reduced the financial surplus.

10.4.5 Responses to external requirements

QOF and GPPS particularly stimulated the development of stronger methods for managing clinical quality, partly because they were contractually compulsory but also because of the information systems, data collection and dissemination which they entailed. PlusPM practice sought ISO accreditation, which among other things involved drawing up an official doctor's bag list, trying to get the (then) four doctors to agree what they should be carrying, and standardising that as a written protocol. In 1995 the practice had also sought ISO standards accreditation for its complaints procedures but that was found too bureaucratic and was dropped in 2004.

The cooperatives also received external feedback about their standards of clinical work, used either as a reinforcer of good practice or to identify weaknesses. Metro won two national awards too for clinical governance and

clinical excellence. It became a national reference site for one of the main OOH call management and operational software providers. At times external feedback was tantalisingly incomplete:

we have had a lot of chuntering about inappropriate admissions out-of-hours and that kind of thing. Every time we ask them [hospitals] to be specific about things so we can look into it, we get a deafening silence. We have tried for as long as I can remember to get copies of discharge reports for patients who have been admitted through our service, and that is completely impossible from any of the local hospitals. They all say that their IT is not up to it.

(GP clinical governance lead, Metro)

PlusPM practice had the problem that different consultants from different specialities recommended different drugs for similar purposes (e.g. choice of preferred ACE inhibitor), so all three ended up in the formulary, which rather defeated one of the purposes of having a formulary.

Because its clinical practice was structured hierarchically (outside the cooperative element of the organisation), comparison with the US consumer cooperative showed how hierarchical and NHOs differed in their modes of managing clinical quality and practice. OverThere relied mainly on line-management, for which they had well-developed routines. Line-management of the doctors extended to their clinical consulting style etc, although with a focus on 'Targets' OverThere relied heavily on routine data to check on and manage individual clinicians, and so raise standards of clinical care (besides responsiveness to patients). Family care doctors were given targets and had monthly print-outs (audits) of their performance comparing it with that of other doctors. They also received direct patient feedback, including complaints, routed via the Director of Regional Clinical Operations. One way in which this manager can alter doctors' clinical performance is by using patient satisfaction data. The example was described to us of a doctor who was failing to spend the period stipulated by management (8.00 to 8.30 daily) for telephoning clients. She said 'I have a lot in my schedule to do. I'm not going to tie down to the phone'. The manager's view was; 'So, she's refusing to do the standard work that we expect everybody to do.' Further investigation by the manager found that she was a very busy practitioner. Her patients received twice as many emails per patient as in comparable lists and counselling also took up much of her time. So now, she and the clinical manager understand and know 'how to help her.'

In contrast the work even of the minority of salaried doctors in our UK study sites was monitored, although still quite closely, through the more collegial methods described above. To summarise, organisations whose structure was based on direct democracy either rotated their less congenial (more routine, lower-status) tasks among the members or partners, or delegated them to employees. Those with a 'representative' democracy allocated these tasks to particular (members, more in the fashion of a hierarchical organisation. The case study organisations attempted to create economies of scale, but existing financial institutions made it difficult for them to

access capital. Development of the core process (innovation) occurred by replication, vertical integration, diversification, external organisations' requirements and re-engineering. In health care, the latter two drew heavily upon evidence-based practice.

11 Outcomes: case study findings

Of the policy outcomes mentioned in the original project brief, the case study findings about external governance, professional engagement, clinical workloads and innovation are reported above. This chapter reports the remaining three: impact on clinical quality and development of best practice; cost-effectiveness; and patient experience.

11.1 Impact on clinical quality and development of best practice

11.1.1 Skill mix

Skill mix was the first structural influence on clinical quality. It was striking but hardly surprising that due to having a pharmacist partner PharmPlus, although a dispensing practice, had a generics prescribing rate (adherence to formulary) above 80% whilst other dispensing practices in the locality barely surpassed 40% because they found it harder to break away from branded drugs.

11.1.2 Mutual scrutiny

Mutual scrutiny was as described above an important governance mechanism and clinical governance was no exception. Because PharmPlus had no personal lists each GPs' practice was more or less transparent to the other GPs by way of the patient record and patient reports. Discrepant or disputed practice (led to discussions between GPs. Significant Event Assessment (SEA) meetings were held monthly with low thresholds for event inclusion, for example discussing misunderstandings about communicating test results to a patient. The PHCT discussed all deaths within the practice population, assessing whether the patient had had the right treatment and whether she died where she wanted to.

At NurseLed one of the nurse partners was clinical governance lead. She took the decision not to employ a salaried GP who the PCT sent:

Well basically he did one session, and I then looked through the, looked through the clinical notes and thought - no, well, sorry!.

(NP-partner, NurseLed)

This was well received by the PCT's clinical governance lead (a doctor):

[NP partner] showed me very early on that she knew what to do and she was prepared to do the right thing ...[NP partner] was prepared to put her name on the line saying these are the problems, this is the documented evidence of what I think is going on here. Whereas some other GP would have written and just said, "I don't like them, take them away" but wouldn't necessarily been able to take on the professional responsibility of getting it sorted out.

(clinical governance lead, PCT)

Members of the English OOH cooperatives who worked clinical shifts were subject to routine clinical audit by the member elected as clinical governance lead. At Metro this director responsible for clinical governance had the task of auditing, seeing doctors who caused concern, and examining a fixed percentage of all the records for every single clinician working for the organisation, in all about 240 calls a month,

looking at ones that result in admission or A&E attendance to see if that was really necessary. We are looking at the duration of the calls, again to make sure that we are offering value for money. We are seeing whether people are prescribing antibiotics appropriately, and sticking to prescribing policies for other medications.

(clinical governance lead, Metro)

For serious breaches of protocols a disciplinary procedure was applied. This was at times triggered by (another member) GP coming across 'something eccentric' (clinical governance lead) in the treatment of her patient. In City routine audits also concentrated on checking compliance with the protocols that existed for most aspects of the cooperative's work. A clinical team took samples of call sheets and looked at them to say whether the medical advice was good and to suggest remedies for any apparent problems (e.g. members not writing sufficiently detailed records of the calls). Mutual education was a counterpart to mutual scrutiny. (Other research (347) suggests that knowledge is necessary for evidence based practice, but not sufficient.) PharmPlus ran a journal club and held a health promotion meeting once a month involving GPs, practice and district nurses. (All the UK health sites arranged time off for professional training for their medical partners and members, for non-medical partners and (more selectively) for employees, although salaried doctors always received the education and training stipulated by national guidance.

11.1.3 Standardisation of practice

Our study sites were also tending to standardise clinical practice during the study period. Whilst not sufficient for the evidence-basing of clinical practice (poor practice might become standardised), standardisation is a precondition for defining the goals and processes of clinical work, and hence for monitoring it (for instance with statistical process control) (348). In PharmPlus the pharmacist partner assembled case management plans for the chronic diseases listed above, and the GPs homogenised their clinical practice toward these more evidence-based protocols. Similarly in a cooperative setting; where NICE guidelines were absent the clinical director at Metro would formulate consensus guidelines, and consult the (GP) membership before adopting and implementing them.

11.2 Cost-effectiveness of service provision

Findings on effectiveness are presented above. Here we present findings as to the cost of providing services.

11.2.1 Breaking even

Across their activities, all the NHOs had to cover their costs within a short time-scale. Trading insolvently was illegal for them as for a corporation. A condition upon making the innovations (and other service changes) described above was that the consequent income stream at least covered the cost of the additional activity. Informants at all the GP partnerships regarded the practice as an independent business. To make any improvements they have to 'find the money from somewhere'. At PharmPlus assessment of the profitability of a new service was a normal step in deciding whether to pursue it. When seeking to admit a new partner, existing partners considered the candidate's personal characteristics but always the affordability too. At PlusPM the goal of providing good quality services could, as related above, be pursued up to the point at which its costs were covered.

In Wholefood too the recruitment of working members was always constrained by their capacity to make a contribution to covering the cost:

We are not a charity. We don't employ ourselves or anybody else under the notion that we're, that they aren't carrying their weight.

(Member, Wholefood)

What the Wholefood members monitored were:

three key performance indicators which are sales, nett profit, gross profit, they're key to the financial control of the business, but they're all general [i.e. each taken across the whole cooperative].

(Member, Wholefood)

A break-even constraint might be an incentive to reduce the volume and quality of services provided, but NurseLed practice resisted it:

Because of our social enterprise background and our high quality service, we try to do everything to the best of our ability but it seems as though sometimes we are rewarded for doing less, and there are ways of coming out with more money for doing less work so we are going to have to … try and keep the good atmosphere that we have, and the high patient satisfaction without it actually being a cost.

(Board member, parent SE for NurseLed)

Similarly at Metro:

If we have to go into the market of providing the cheapest possible care regardless of quality, then we don't want to do that. There is no point in us being there to do that, so we are not prepared to cut quality to get the contract at any price.

(clinical governance lead, Metro)

Interestingly a director of the GP-owned company which supplanted a failed cooperative said almost exactly the same:

it [out-of-hours cover] wasn't going to be at any cost, that whatever we came up with would be costed fairly but that if we tried to get beaten down too much and end up trying to provide a service that we thought was clinically sub-standard, then basically we weren't going to be interested.

(GP, PLC director)

Such similarity across different organisational settings suggests that professional standards and values influenced these views no less than organisational structure. At OverThere changes to services were usually presented (inter alia) in terms of budgetary effectiveness even when they were also congruent with the philosophy of the organisation. Thus preventive care:

is what you really want us to do to the patients. In order for us to be able to do it, we need to be affordable. In order for us to be affordable, we have to go through some efficiencies in our practice, in our style.

(Manager, OverThere)

Being a large organisation did not necessarily improve financial stability. Metro had a multi-million pound turnover but not a huge asset base to back it up. It could run at a small loss for a year or two but not withstand any big losses. When the PCT which contracted City got into financial difficulties, they cut the City's development funds down stepwise to zero over three years. In this cooperative:

The aim has been to break even with a small reserve of course because we need it to exist, but with the change in the GP contracts, although we didn't want to make too much surplus, we couldn't afford to just break even because economies of scale would have been lost if members opted out.

(Finance Director. City)

Still, however, a determinate income was required: 'Break even' plus contingency reserve. HouseLend implicitly included development funds:

we've passed that value [surplus] through to our members by better product rates and we're always trying to have a fine balance passing that value to them through the products this year and retaining profits to go into our capital to protect us and to make sure we have sustainability for future members.

(CEO, HouseLend)

11.2.2 Costs to purchasers

The out-of-hours co-operatives had two sources of income. For patients of the general practices which opted out of providing out-of-hours care, the PCT made a contract with the cooperative. If they chose the cooperative to provide these services, the opted-in practices paid the co-operative directly. Like the practices described above, the opted-out general practices wished to contain their costs, in this case within the amount nominated for OOH services in their contractual payments from the NHS. At City the CEO

presented his estimates of local general practices' average incomes, and the percentage of that income which was (notionally) allocated for out-of-hours service, which came to £3.24p per patient per year.

So essentially whatever pricing mechanism we had ' there was a range and you could never go beyond £3.24 if you were to stay as a co-operative.

(CEO, City)

The income stream from the PCT was more-or-less fixed. Were they limited to that income, the cooperatives had little scope for extending the scale of services provided, only for reducing costs of the existing services. The second income flow meant the cooperatives could increase their income by recruiting new (opted-in) members but not by adding cost-bearing features to those services.

City partly passed the savings it made from economies of scale back to its members but also tried to benefit the local health economy more widely, so as to give its PCT an incentive to continue to commission the cooperative. To do so the cooperative instituted an incentive for its members:

if they [GP members] have all the incentives to send patients to [City], the A&E benefits, the PCTs benefit, and we benefit, which is very good. So we said 'what we will do is we will create a ceiling [on referrals or self-referrals to the cooperative]. So I looked at the mean of all these practices, and I added 25% beyond the mean. And then I said that this is your ceiling, and if you go beyond that ceiling 'you need to start paying for activity.

(CEO, City)

The other free benefits that City provided to its members were sufficient to prevent the members with lower than average referrals from leaving the cooperative. The savings from economies of scale helped keep the cooperative's price low to members and the PCT, creating a barrier to entry for potential competitors (except those who could afford predatory pricing).

Outside the NHS, HouseLend had a policy of charging and offering 'fair' but not 'market-leading' rates of interest for borrowers and savers. Its strategy was not to recruit 'rate tarts'as customers but retain customers through the quality of customer service. Their usual customer demographic was people over 65 years of 'high net worth' looking for a safe place to save their pension or life savings. The two retail cooperatives both operated in very competitive market niches. Their prices were therefore competitively constrained but both cooperatives tended to focus on non-price (quality, product-range and for the larger cooperative, brand) competition.

11.3 Patient outcomes and experiences

11.3.1 User influence on providers: mandatory feedback mechanisms

General practices' processes and structures for obtaining data about patient experience and service outcomes were in part mandated externally by NHS

commissioners. Except for consumer surveys, marketing (even social marketing) methods were not used, except that Metro employed Metro a marketing and PR manager.

As QOF required, PharmPlus, PCTrun and NurseLed all used a standard NHS patient feedback questionnaires (GPAQ). However the nurse-led practice found that GPAQ needed adjustment for its circumstances:

it's very hard when the question is 'How often do you see your doctor?'and the answer is "Never, I can't get to see a doctor".

(NP partner, NurseLed)

All three sites fed the data back to the PCT and internally to GPs and staff. Data from patients' letters and complaints were collated. At NurseLed a partner dealt personally with any complaints, trying to speak to the complainant straight away. For PlusPM, GPAQ superseded a survey of the practice's own devising. A suggestions box yielded few responses but those that came were often useful (e.g. to fit plug covers to electric sockets in the play area).

City patients usually only contacted them by telephone, which was the normal but limited mode of collecting any feedback patients wanted to make. Otherwise the patient contacted her general practice which passed the message on to City. Both City and Metro had a formal complaints procedure which (for complaints concerning medical advice or treatments) involved the doctor giving the care and, at need, the Medical Protection Society. OverThere relied on routine information systems for feeding patient responses back to doctors. Tools to gauge patient satisfaction included 60 randomly-distributed patient questionnaires from each panel each month. Each practitioner had a confidential provider dashboard which recorded how many patients reported that the doctor listened to them carefully, spent enough time with them and so on. Complaints were routinely monitored by business directors. OverThere also made it easy for patients to choose their doctor on the basis of CV and background:

I went back to the sign up place and said, "Is there any way that I can change doctors?" and they said, "O sure" They handed me a list of three ring binders and said "Here are the ones of your geographic area who are currently accepting". On this was a different page from each one talking about not only their speciality background and their general background, but their personal interests, things about themselves.

(Patient, OverThere)

She chose a middle-aged woman doctor with grown up children like hers and hobbies that she could relate to.

11.3.2 Patient participation groups

Some study organisations tried patient participation groups as a means of user feedback but found it hard to make much headway. In PharmPlus a previous group failed because it was 'grown from ground up', so for its second attempt the practice selected members to give a geographical

spread and include the most vocal people, but not overly vocal dissenters who it was felt might misuse the group. In NurseLed too:

we're in discussion now in the Practice Meeting to set up a Patient Participation Group but it doesn't seem to be the right sort of people who want to get involved.

(NP partner, NurseLed)

PlusPM had a different problem. Past efforts to run such a group only produced one or two attendees and meant a working evening for the partners. City's experience was similar:

There was talk about having patients on the council but it is very difficult to work it.

(Finance Manager, City)

Instead City was often invited to send a representative to patients'meetings within City members' practices. Patient representatives from the PCT also visited City and City reported to them.

Contrary to our expectations HouseLend was not keen on customer groups either, although in that regard they were atypical of building societies:

We are not known for holding customer groups or anything like that, we might test the odd new product or marketing initiative but by and large 'unlike some of the building societies 'we don't do that, we rely on a daily basis on getting feedback through the branches in particular.

(CEO, HouseLend)

As our fieldwork was finishing Wholefood were on the verge of setting up a 'customer service team' to work across its shop and its cafe. Until then, this small cooperative had relied on members' informal feedback and observations and till takings for monitoring what customer thought of its products and services. The large retail cooperative used relatively conventional consumer research and tracking methods.

Patient groups served two different functions at OverThere. One was exercising governance over the whole organisation, as reported above. For feedback on services, OverThere had different groups for its two main subscriber segments. For individual patients, focus groups were convened around specific issues. The attendees were called 'consumer consultants' However, the results of these focus groups were not routinely fed back to consumers, still less any practical consequences of their views. As for employers, Leadership Advisory Groups (LAGs) were recruited from local business leaders (i.e. the sort of people who might buy OverThere coverage for their workers) as a market research tool for the purpose of gathering information around specific issues, as and when OverThere desired. These groups were controlled by management and so, though officially placed within the 'cooperative governance structure' were tools for user feedback rather than user governance.

11.3.3 Patient experience and feedback

Although partners' and employees' interpersonal behaviour was an important element of patient experience, partnerships did not always manage it successfully:

For example, there's a lady on reception who has been rude to not only the doctors, but the patients as well, and nothing has been said to her in the past ' because the situation has been allowed to go on for so long, it's very hard now to take that person to task for something that they have been doing for years.

(employee, PlusPM)

However the same could apply to partners:

The doctor failing to perhaps see that he needs to be a little more empathetic with people that come in and needs to listen. I suppose it's down to how many years they've been in the practice possibly.

(supervisor, PlusPM)

Nevertheless GPs often attached high value to being central to the patient's care:

I hope we don't become a part of [supermarket-chain]-doc because I kind of worry that people will get the brand. "This is what you get, this is what you can have" type thing, there will be the lack of continuity, you will never have the relationship that you have with patients because the patient will come in and see a doctor, not their doctor, and I think people will only miss it once it's gone.

(GP PlusPM)

This role of the doctor was also important to some patients at NurseLed:

Some people left because they wanted to see a doctor all the time and I have to say I don't try and stop them because we're not going to provide a doctor to sort out minor ailments or monitor your blood pressure. Whereas most patients when they've got to know the people involved they don't mind what the role is if they feel that the person is looking after them and that's now where we're getting to. But they frequently refer to Nurse Practitioners as the doctors 'I think the message from that is they are getting the care they think they should be getting from a doctor.

(NP partner, NurseLed)

Since nurse practitioners and GPs have different repertoires of clinical skills, the similarity in patient experience would appear to stem more from the character of personal relationship between clinician and patient. However, City staff wondered whether it was their place to form a long-term relationship with patients (except for patients with long-term or terminal illness) because, to them, that implied substituting for the role of a GP or that the GP was providing inadequate care. A HouseLend branch manager told us that what was of primary importance in recruiting staff was the ability to talk to people, show an interest and ask open questions;

though it is a sales role, we see it as a service role.

(Branch manager, HouseLend)

The customer was not to be pressurised into buying a service (in contrast, a former bank employee told us, to corporate banks). At HouseLend only financial advisors, not branch counter staff, actually did any selling. It was a rule that nothing was to be sold at the customer's first visit so that customers had time to think carefully before committing to anything. The Society was against waiting time targets because such targets can reduce customer service: 'Each customer gets as long as it takes.

(Branch manager, HouseLend)

Wholefood took a more robust line on empathy with customers:

Our basic ethos in terms of customers [is], we try and treat customers fairly and we take great stock in being friendly and giving good service but 'we don't have that "have a nice day". If the customer's gonna be a stroppy cow, then we can turn around and you know [say] 'Clear off' we don't have that dreadful [fast food] sort of service, we try and be one human being to another human being.

(member, Wholefood)

OverThere found that their members were sensitive to 'and suspiscious of - the use of corporate-style language and other symbols of organisational culture, and of use of the term 'customers' rather than 'members' to describe them.

English general practice informants repeatedly cited QOF and GPPS scores as evidence of the quality of services to patients. Appendix 6 presents (except for out-of-hours services: see Table 5) the scores corresponding to the issues which arose from the qualitative data for the general practices studied and, for context, mean figures for England. Patients rated our study sites equal to or slightly better than the English means for 8/24 of the questions. The other site scores were distributed either side of the means. Thus our study general practices scored slightly higher on patient satisfaction than the generality of English practices. NurseLed's profile was distinctive: below-average scores for the questions about doctors and scores equal to or above average for the questions about nurses. However these differences between NurseLed and the other sites should not be over-interpreted. The GPPS questions were not designed for nurse-led practices with their atypical nurse and doctor roles. Strictly speaking GPPS has no response categories for a nurse-practitioner acting as clinical principal, making it difficult to say confidently how NurseLed patients interpreted the GPPS questions.

Table 11. Summary QOF indicators for study sites

QOF indicator	PCTrun	NurseLed	PlusPM	PharmPlus	England (mean)
Total QOF points (out of 1000)	948	1000	996	1000	968
Clinical QOF points (out of 655)	629	655	655	655	630

Source: QOF indicators for England 2007-2008, rounded to whole numbers.

Again this table should be interpreted as a supplementary description of patient experience in the particular study sites not as evidence about different types of partnership generally. Only PCTrun fell slightly (<2%) short of mean scores for England. This time comparing GPPS scores for out-of-hours services, Table 12 uses a similar method to Appendix 6. The method by which the scores for cooperatives were calculated is explained above (methods).

Metro achieved slightly higher than UK mean levels of user satisfaction and City somewhat lower levels, although the data do not allow us to calculate whether these differences are statistically significant. They suggest that between them the two cooperatives studied represented a qualitatively typical sample in terms of quality of service as users perceived it. Metro achieved nearly 98% compliance with the national out of hours quality standards (349), compared with the norm of 95%.

Table 12. Out-of-hours services GPPS scores

GPPS item	Metro	City	PCTrun	NurseLed	PlusPM	PharmPlus	England (mean)
Q30 - If you wanted to, would you know how to contact an out-of-hours GP service when the surgery or health centre is closed? [% yes]	62%	55%	63%	57%	66%	77%	67%

Q32 - How easy was it to contact the out-of-hours GP service by telephone? [% Very or fairly easy]	83%	71%	70%	0%*	42%	86%	79%
Q33 - Were you prescribed or recommended any medicines by the out-of-hours GP service you contacted? [% yes]	56%	48%	59%	0%*	42%	50%	53%
Q34 - How easy was it to get these medicines? [% very or fairly easy]	87%	71%	0%*	0%*	0%*	0%*	85%
Q35 - How do you feel about how quickly you received care from the out-of-hours GP service? [% about right]	68%	55%	76%	0%*	62%	55%	64%
Q36 - Overall, how do you feel about the care you received from the out-of-hours GP service?	69%	57%	0%*	0%*	0%*	67%	65%

** Data negligibly small, suppressed. Source: GPPS data 2008-2009.*

For OverThere the simplest form of patient feedback was membership. That appeared to be declining, in 2006 by 27,000 people according to OverThere's figures. OverThere was above the national mean for 27 scores and below it for nine of the HEDIS indicators for quality of care (350). Of the CHAPS indicators, OverThere was above the national mean for five scores and below it for four. It rated 'excellent' on the (US) National Committee for Quality Assurance report card scheme.

For the non-health cooperatives sales and market share were also a basic form of customer feedback. So, for the smallest, was the behaviour of potential competitors:

part of the reason that [two well-known supermarket chains] and these kinds of people are getting temporarily interested in organics...is that they're threatened by organic products...[and have] sufficient financial clout and resources.

(Member, Wholefood)

Setting this speculation about corporate supermarkets aside, the small retail cooperative and its consumers anticipated wider food retailing market

trends by some years. In sum, mutual scrutiny ('concertive control') supplemented with mutual education was the crucial mechanism for managing the quality of services to (users. External competition and commissioners' requirements were the most important cost control mechanisms. User participation was a means for (limited) user influence on the governance of the study organisations but routine collection and analysis of managerial and clinical data was a much more effective means of monitoring, and therefore initiating improvements in, service quality.

12 Combined findings and discussion

Our descriptive findings show that the organisations we studied were in the most important respects similar in organisational structure to those described in the systematically review, making it legitimate to combine the primary and secondary research findings, which is what this chapter does. As previously explained (ch.4) we use the theoretical framework (ch.2) for collating and combining the findings. In doing so we also indicate the extent (as a proxy for strength) of the secondary evidence reviewed. 'Many studies' means studies reporting more than one sector or country. 'Rarely reported' refers only to the studies we reviewed. In the reviewed studies, the absence of evidence of patterns is also noted but this counts as evidence of absence only where the original researchers looked for the pattern in question and did not find it, a detail which the published papers seldom reported. Combining the two sets of findings in this way allows a direct, systematic comparison between them and the original theoretical framework. In light of the comparison we revise the theoretical framework as necessary to fit the combined evidence and consider any wider theoretical implications of that follow.

12.1 Environment of non-hierarchical organisations and professional partnerships

12.1.1 Organisational goals

Evidence in the case studies, systematic review or both confirmed the importance of non-economic goals, especially those of maintaining service quality, working conditions and work 'enablement'; and of cooperation as valuable in itself. Especially during the 1970s and 1980s many NHOs were founded to rescue a firm from market failure. Ideological goals were more important for producer than consumer cooperatives or mutuals, where the goal of obtaining high-quality goods and services at an advantageous price predominated. Corroborated goals of partnership-formation included: limiting liability risks; offering mutual practical assistance; allowing the partners to pursue interesting, stimulating work; pursuing economies of scale (even if these were not always achieved in fact); and developing a more sophisticated practice infrastructure (including employed support staff) by pooling resources. Partnerships also had the goal of widening the range of services they offered and, outside the health sector, increasing their market power. NHOs and partnerships both had to satisfy break-even constraint. Their income had to cover members' or partners' incomes, a contingency fund and product or service development. However our combined evidence does not generally support the (assumption that partners or cooperators wanted to maximise (rather than satisfice) their

income. Both our case study and our review evidence showed the importance of local affiliations among the goals of NHOs, and to a lesser extent partnerships.

Other predicted goals were not fully corroborated. Countervailing the (healthcare commissioners' market power may be an important goal of US medical partnerships but we found little evidence of it elsewhere. If 'professional mimesis' means more than 'compliance with professional norms of practice', we found no case study evidence of professional mimesis as a goal in forming or developing partnerships, and no direct evidence in the reviewed studies either. Mimesis of corporate management was reported both in our case studies and the review, but not as an organisational goal in itself. Thus NHOs and partnerships have complex, multiple goals with financial goals not necessarily dominating. Besides securing an target income (82,83) members' or partner's financial goals in setting up an NHO or partnership were generally two: risk reduction, in the sense of sharing workload in order to even out fluctuations between members or partners, and over time; and strengthening the members' or partners' joint bargaining power (for instance by collectively strengthening their reputation or 'brand'). This pattern calls into question the empirical relevance to NHOs and partnerships of neo-classical micro-economic assumptions about the firm. Instead of profit maximisation in the sense of maximising income paid to external shareholders, we found stronger evidence of the goal of breaking even at a level that covered somewhat higher than market rates of pay. That goal is of attaining a given income at minimum cost rather than one of maximising profit from a given set of inputs. Empirically the partnerships (faced economies of scale at sizes below about 10 partners, but thereafter dis-economies. This (picture conforms to the U-shaped cost curves which neo-classical micro-economics assumes firms to face. NHOs however faced straightforward economies of scale. However the composition of NHOs' and partnerships' costs was different to that of the corporation because NHOs and partnerships generally did not pay much, or any, dividend, interest or similar rents to external recipients. Many assumptions of the neo-classical economic theory of the firm were therefore generally not true of partnerships and NHOs. We conclude that the economic analysis of NHOs and partnerships requires drastically revised micro-economic models whose assumptions are consistent with the combined evidence above. We found no case study evidence that partnerships or NHOs were ever formed with the conscious goal of reducing transaction costs. Although the systematic review papers sometimes discussed transaction costs, they presented little direct evidence that reduction of these costs was what consciously motivated the formation of NHOs and partnerships. They presented little direct evidence that lower transaction costs then those of other governance structures were an observed effect of partnerships (or of NHOs). Our combined evidence suggests that so far as NHOs and partnerships are concerned both types of economic analysis are unrealistic in the sense (351) (that they do not describe empirically observed (economic) mechanisms or processes,

although that criticism might have less force against more sophisticated variants of neo-classical economics such as the New Institutional Economics and behavioural theories of the firm which relax some of these unrealistic assumptions. In the face of similar criticisms elsewhere (e.g. (171)), a standard defence (352) of such theories is that they nevertheless generate valid predictions. We consider that point below.

12.1.2 External governance, incentives, regulation

The importance of the policy, legal and regulative environment for (enabling or destroying non-hierarchical organisations (depending on national and international policy-makers' preferences) was also confirmed. (Indeed our theoretical framework underestimated the importance of certain policy contexts for founding NHOs. In central and eastern Europe, one such goal was 'soft' privatisation, a politically defensible preliminary to complete marketisation of the economy or, whilst the USSR still existed, for distancing producer organisations from the state (152). Our data about the effectiveness of contracts as a medium of external governance concerns partnerships rather than NHOs. Many studies including our own case studies show that incentives strongly influence medical partner behaviour. (However, the effective incentives include collective ones. The effectiveness of governance of partnerships through contracts depended on precisely what outputs or outcomes attracted payment. The most effective forms of contract for public commissioners to use were those containing clear, specific targets whose achievement (or not) was unambiguous, whose targets and other stipulations appeared legitimate (or at least, practically helpful) to the provider, and which were incentivised. (Evidence-based guidance and contracts tended to level up service effectiveness ('quality'). An important mechanism for this, many studies show, was making practitioners' performance against contractual targets transparent to scrutiny, both within the partnership and externally. This approach, however, works most effectively when the contractual targets are evidence-based which is feasible for clinical practice but not necessarily for, say, law. Within these constraints, 'light touch' external governance allows greater flexibility of the contracted organisations (including NHOs). Competition between partnerships produces less collegial, more target-oriented, managerialised modes of work. Both the case studies and systematic review papers described NHOs and partnerships having to operate within legal systems which assumed corporations as the normal organisational type, to the neglect or exclusion of NHOs' or even partnerships' requirements, for example by treating members' and partners' person income as 'profits' equivalent to shareholders' dividends, with the side-effect of inhibiting NHOs' and partnerships' operation or development. Financial institutions similarly were oriented (primarily towards corporations. When law and regulations are oriented towards partnerships they are nevertheless liable, English law included, to treat dental and medical general practice as the default model to the neglect or exclusion of other partnerships of other

health professional partnerships. English law also does not limit the personal liability of professional partners.

Perceptions of tension between market imperatives and the goals (and ideologies) of professional partnerships were reported both in the reviewed studies and our own informants. Yet our combined findings also suggest that partnerships are in certain respects more 'at home' in market economies than NHOs are (156). Thus a part-answer to the question 'Why are worker cooperatives so rare?' (147,196) is: because the policy, legal and financial institutions of developed capitalist societies are often indifferent or inhospitable to them. For partnerships are generally structured and managed more like small owner-managed businesses than NHOs are, and have a similar equity-structure. NHOs are more likely to have an anti-market or anti-corporate culture. Being managed and differently regulated , however, (quasi-markets offer the opportunity to create environments more favourable than conventional markets to NHO development.

12.2 Organisational structures

12.2.1 A taxonomy of non-hierarchical organisations

A taxonomy of partnerships and NHOs emerges from our combined findings, a taxonomy based on organisations' membership and goals. Their members' goals will, on the above theory, require a core productive process to realise, hence an organisational structure to operate (coordinate) that process. Different types of goal and therefore core process are therefore what fundamentally differentiate taxa of organisational structures. For the kinds of organisation studied here the fundamental distinction in goal and process is between producer and consumer organisations. Because production for is their core process, organisations (e.g. some former US communes) which produce goods or services solely for their own members' consumption must therefore be considered a sub-species of producer organisation (96). Among producer and among consumer organisations are both non-hybrid and hybrid variants, differentiated by whether they restrict the electorate of their internal democracy and who (concomitantly) receives (income only from their own work or also profit from their employees' work. Partnerships are then the special case of hybrid structure within which equity ownership is the property-qualification for participating in governance. Professional partnerships add the further qualification of (having the right to pursue a legally-closed occupation. A non-hybrid partnership would be structurally indistinguishable from a 'pure' non-hierarchical organisation (co-operative).

All this implies the following structural taxonomy of the organisational studied above:

1. Producer organisations:

    (a) Non-hybrid ('pure') non-hierarchical producer organisations.

(b) Hybrid non-hierarchical producer organisations, with subsets:

i. Producer organisations without property qualifications for voting or office

ii. Partnerships

A. Equity partnerships

B. Professional partnerships

2. Self-help non-hierarchical producer organisations, whose members produce goods or services for their own use. Consumer organisations:

(a) Non-hybrid non-hierarchical consumer organisations.

(b) Hybrid non-hierarchical consumer producer organisations (no subsets).

As previously explained, NHOs and partnerships are a subset of social enterprises and a subset of not-for-profit organisations. English policy discourse tends to lump all these organisations, and others such as charities and religious organisations, together as the 'third sector'.

12.2.2 Structures, management and 'degeneration'

The presence and operation of technical persuasion, ideological (normative) persuasion, mutual scrutiny and concertive control, pay incentives and expulsion as co-ordination mechanisms were all broadly corroborated by both the review and the fieldwork. So was the relational, consensual character of decision-making in small organisations, partnerships and NHOs alike. Evidence-based practice was an important homogeniser of working practices in the healthcare partnerships and cooperatives. Interpersonal skills and team working proved more important coordination mechanisms than we initially assumed, and expulsion less. The fieldwork and the systematic review both strongly indicated the centrality of mutual scrutiny and concertive control as a coordinating strategy in both kinds of organisation. Weak or slow consensus decision making was reported in one consumer and one producer NHO but not the other case study sites. Secondary sources rarely if ever reported it as a problem. Generational attrition of cooperative or egalitarian values was found in two of our case study consumer NHOs and non-health partnerships but not in the producer NHOs and health partnerships. Many studies in the systematic review reported generational attrition of cooperative or egalitarian values, especially in the countries central and eastern Europe. The phenomenon was not reported in partnerships.

An important empirical qualification to our initial account of workplace democracy is to notice the apparent necessity, for operating many kinds of core process, of structures in which staff do not elect or recall their own immediate supervisor. Our findings suggest that two polar models of NHO structure are compatible with it long-term survival and effectiveness (in

terms of meeting its own objectives). One is the direct, relational democracy of the self-contained workshop (or clinic, hospital ward, department, office, team) with its reliance on everyday peer scrutiny, concertive control, and consensus or voluntary allocation of tasks and positions of responsibility. The other model is analogous to an elective presidency. The members elect the CEO executive and perhaps the board, who until the next election exercise a temporary hierarchical control over their electors, typically through a chain of middle managers who are salaried employees and cannot be voted out by their subordinates alone.

Either model can be effective over long periods, raising the question of what conditions each is best adapted to. Our combined findings suggest it depends on:

1. The extent to which external discipline is necessary to get the members to operate the organisation's core productive process. This depends on the character of the core process (whether it is disagreeable work, occurs at inconvenient times or places, requires reliable attendance at the same time as other workers, is hazardous etc.), hence whether the worker is intrinsically or extrinsically motivated to do it.
2. The homogeneity of the workforce in terms of skills, motivation and social status. Direct democracy and concertive control apparently function more effectively within occupational groups than between them.
3. Speed of decision-making required. Under relational (direct) democracy decision-making is fast in small groups (e.g. partnerships) and can to a certain extent be streamlined in larger entities (e.g. decision by vote rather than consensus). However in large organisations especially, decision-making by a single person is almost bound to be faster. Whether faster is necessarily better decision-making is another matter.

The more external discipline is required, the more heterogeneous the workforce, and the more often fast decision-making is necessary in a large organisation, the more effective the elected-CEO or board structure rather than direct democracy is likely to be. In consumer cooperatives there was so to speak a 'ladder' of member participation but the case studies and the reviewed studies gave conflicting evidence about whether this situation reflected a degeneration of member control. In our case study sites degeneration of member of control was more apparent in consumer than producer cooperatives but that difference was not so marked in the systematically reviewed research. The subjoined hierarchy tended to be proportionately larger and of greater practical importance in consumer cooperatives, mutuals and partnerships than in producer cooperatives in our case studies. The reviewed studies indicated however that a non-hierarchical producer organisation could under certain conditions survive having as much as 40% of its workforce as employees.

Other assumptions about organisational structure were more substantially qualified or even refuted by our case study and review findings. The allocation of rewards, especially outside the health sector, was often more complex and subtle than the simplistic assumptions of neo-classical micro-economic models. Instances of equal distribution were found, especially in NHOs and healthcare partnerships. However more complex arrangements were described which partly reflected 'contribution' (mainly, income generation) but diluted or compounded these incentives with others based on seniority, technical skill, family income 'needs' or simply colleagues' good opinion. Decision-making was slow in some of our non-hierarchical case study organisations, though without the organisationally fatal consequences which some theories predict. In other study sites it was not slow at all. Tournament career practices were described in the reviewed literature but not found in our study sites. In any event, such systems are not restricted to partnerships (they exist for instance in medical and academic bureaucracies), are absent in a substantial minority of partnerships and (e.g. as apprenticeships) exist a minority of producer NHOs, corporations and public bureaucracies. So they are an incidental not a defining structure of partnerships. The symbolic importance of an inspirational founder who personified organisational culture and ideology to following generations was an unforeseen finding.

Of our case study sites, Michels' 'iron law of oligarchy' (57) appeared to have some application to one large non-hierarchical consumer organisation and to the partnerships, but less to the other NHOs. Stratification of the relevant occupations even within partnerships was corroborated in both case studies and reviewed literature, especially studies of NHO workforces in the countries of central and eastern Europe. Insofar as managerial capture of NHOs occurred, it was through:

1. Activists being compliant and relatively few, although the nominal membership was many times larger; in our building society study site, tens of thousands of times larger.
2. A large subjoined bureaucracy with specialised staff whose functions were not necessarily intelligible or transparent, or even legitimate, to the members.
3. Managers becoming conscious of having a distinct interest and role apart from the members.
4. Managers having weaker normative attachment to the NHO's mutualist or democratic organisational structures, management practices and goals than to corporate ones.

Degeneration appeared harder to prevent in consumer NHOs with their dispersed memberships in whose lives the organisation played a small part, than in producer organisations with the opposite characteristics. It appears that consumer NHOs must often rely on a minority of 'true believer' members to exercise control and prevent the NHO degenerating.

But was it of any practical consequence if managers captured control? Our findings suggest that it depended upon how far managers' motivations, normative beliefs and interests aligned with the members'. Alignment appeared to become less likely, the greater the difference in occupation, biography and beliefs between members and managers. Our own financial services case study and recent historical experience in that sector show the importance of managers' commitment to the principles of cooperation and mutuality. One can contrast:

1. HouseLend, where the consequences of manager control ensured survival of the organisation in its mutual form. Managers thwarted attempts to convert HouseLend into a commercial bank.
2. Northern Rock BS, whose managers converted a mutual building society into a corporate bank and began operating accordingly, indeed going further than older corporate banks did in relying on wholesale credit markets for their financing, raising loan-to-value limits for mortgages and making risky ('sub-prime') loans. Other converted mutuals did likewise (328).

These polar scenarios contrast with the gradual erosion of mutualist beliefs in OverThere in favour of managerial beliefs, norms, practices and language copied from corporations. The difference between these scenarios appears to stem partly from such contingencies as the outcome of members' votes, hence the voting members' perception of their own interests,and partly from the ideological standpoint of the managers themselves.

Mutation of partnerships in corporations was not observed in our study sites although the reviewed literature discusses it. Nevertheless our findings evidence the following trends:

1. Stratification and role specialisation within partnerships (emergence of managing-partners, partners with special interests, multi-professional partnerships, employed non-partners).
2. Growth of partnership size
3. Growth of subjoined hierarchies, both absolutely and in proportion to the number of partners. Then a growing proportion of partnership income derives from the work of employees rather than of the partners, and a hierarchical the culture prevails more widely in the organisation as a whole. Many studies reported a tendency for partnerships to become more bureaucratic, the more wage-workers they employed.
4. Formalisation and normalisation of work (e.g. EBM, QOF) with increasing external scrutiny of it.
5. Shift from personal towards external, often corporate, capitalisation, including creation of parallel corporate structures.

Yet the partners remain in control and their original goals for the partnership remain more or less stable. That far,

Introducing outside experts such as a human resources manager might make the firm more "business-like" in its selection or promotion policies but unless they break the control of partners over decision-making they do not alter the firm fundamentally away from the P^2 archetype.

(115); p.97

Yet the question remains of how far these changes can go until the partners (concentrate on managing their employees' work instead of doing their own, increasingly marginalised, productive work. Then, in terms of goals and structure the partnership converges upon another archetype, not the corporation but the hierarchical, non-profit social enterprise. Indeed the NurseLed partners were deliberately following that trajectory.

None of our case studies allowed us to observe whether increased (employment of wage-labour led to the organisation's 'degeneration'. Many studies report NHOs employing wage-labour, but of these only a minority of studies report degeneration, the rest no degeneration.

12.2.3 Professions in non-hierarchical organisations and partnerships

Our case studies suggested that professional engagement in NHOs was promoted by high pay; the importance of the organisation's decisions and activity for other aspects of the professional's life; contact with fellow-professionals; and a well-organised support infrastructure. Secondary sources confirmed that pay for most NHO members, apart from managers, was usually higher than in corporations and pay differentials were lower. Professionals in NHOs tended to have a strong intrinsic motivation to work. Well-developed pro-NHO ideological values strengthened professionals' engagement, but could also cause splits in the organisation. Professional engagement in partnership was promoted above all by ownership and control of the practice, but also by having a profile of work matched to the professional's personal interests. Both the case studies and systematic review found that a well-organised support infrastructure tended to increase professional engagement; and that salaried professionals concentrated on technical not managerial work. The systematic review added that partnerships benefit professionals through risk sharing, increased bargaining power with commissioners, reduced managerial work, and equity gains. Ideological uniformity among partners also promoted engagement with the practice. Disagreements over income distribution were the thing most likely to cause professional disengagement from partnerships.

12.3 Process

12.3.1 Workloads, job satisfaction and morale

In healthcare NHOs and partnerships alike, our case studies found, (professionals tended to take on increasingly skilled work and standardise clinical practice. These trends tended to increase their workload but also job satisfaction. The pursuit of non-economic values was a motivator. Studies in the systematic review corroborated that out-of-hours cooperatives tended to improve GP job satisfaction, morale and income. In partnerships partners did more managerial work, hence more work overall, than salaried doctors. Pay was an important influence on professionals' job satisfaction. In English general practice, the QOF element of GP contracts increased GPs' managerial work but also their rewards, both financial and professional. Positive QOF and GPPS feedback and raised pay and enhanced morale. Review studies suggested that work satisfaction was reported greater where team climate was better and its work accorded with professional values.

12.3.2 Innovation

Case study and systematic review data alike suggested that NHOs tended to diversify their work in order to spread the risk of losing contracts and to improve the quality of working life. They are reluctant to reduce costs by reducing quality of service. The review added that NHOs expand less fast than corporations, tend to be less capitalised and have a wider range of services than corporations do for marginalised groups. NHO tend to face (but (under-exploit) economies of scale (economies of scale in production. (Economies of scale may peter out in partnerships once they grow beyond about ten partners. Partnerships' patterns of innovation were extensive replication, vertical integration, diversification and 're-engineering'. The systematic reviewed added that partnerships expand less fast than corporations. Partly in response to financial pressures, US medical partnerships were increasingly participation in primary care networks. They probably faced economies of scale up to a size of about 20 partners, but not beyond. Theories of innovation suggest that innovations are more likely to be adopted when compatible with existing working practices, organisation members' 'values' and ways of measuring 'success' (177). Hence innovations which conserve an organisation's existing goals, division of labour, patterns of control and benefit-distribution are the most likely to be adopted. Such general formulations however abstract from an important explanatory question: what goals, whose goals, control and benefits, and what benefits make patterns of innovation in partnerships and NHOs differ from those in other organisational structures? To a small extent our empirical findings contribute to filling that gap. They concern both technical and organisational innovations. The goals which partnerships and producer NHOs pursue when innovating are those of the partners and members respectively (not shareholders or the state). Their goals tend to include a

satisfactory quality of work and working life as the partners or members define them, security of their livelihood, and non-economic social or policy 'values' (e.g. contributing to local employment or development). Their financial goals are to break even (at a satisfactory level of pay) in contrast to maximising shareholders' profits (as corporations do) or (like public bureaucracies) minimising costs and implementing current policy. Producer NHOs and partnerships like corporations consequently spread risks to their income by diversifying, but unlike corporations do not readily do so by innovations which would replicate their services beyond the organisation's home locality. Within that limitation producer NHOs and partnerships, like corporations, expand by replicating (which implies innovations that standardise) their services in order to realise economies of scale, and by vertical integration. Like corporations, they do so partly to spread risks to their incomes, but (less like corporations) they also do so in pursuit of what the partners or members, perceive as technically good product quality rather than pursue marketing innovations.

12.4 Policy outcomes

12.4.1 Clinical quality and best practice

Health care NHOs, according to our case studies and secondary sources alike, developed clinical quality through the application of EBM-based protocols, mutual scrutiny and education, concertive control, and the use feedback from external providers. NHOs generally market services on quality not price. Internally NHOs appeared, in our case studies, to have more uniform medical practice than partnerships. Many studies, and our case studies, indicate that these mechanisms of skill mix adaptation, collegial self-education, and the standardisation of clinical practice (EBM) also operate in professional partnerships. Mutual scrutiny is an important means of quality control. Because partnerships are collaborative, the calibre of her colleagues affects each individual partner's performance. Many studies suggest that the combination of EBM, guidance and incentives appears to raise clinical quality but more for acute than socially-oriented care. In these circumstances partnerships appear to provide similar quality care at lower cost than corporate provision.

12.4.2 Adherence to external performance targets

The factors which the case studies and systematic review both suggest promote NHO and partnership adherence to external performance targets are outlined above. Adherence to external performance targets is a goal not relevant to most partnerships and NHOs, hence not widely studied. The English NHS is an exception. Our case studies, the systematic review, and published administrative data all indicate that given the institutional arrangements described above, NHOs and partnerships alike are capable of close adherence to external performance targets, although the two types of

organisation face largely incommensurable targets and so one cannot empirically state which type of organisation is more adherent.

This pattern contrasts with most implementation studies, whose staple fare is implementation deficit. The implementation surplus would appear to have arisen from the combination of five main factors. The policy promoted evidence-based technical processes. It was unambiguous and well-defined. Its implementation structure was simple, with only a few intermediaries between central governance and NHS primary care providers, and the latter were a fairly homogeneous group of implementers. Not least, they were organisations of a type whose goals included maintaining the quality of clinical care for its own sake; professional partnerships and NHOs modelled on professional partnerships.

12.4.3 Cost-effectiveness of service provision

Many predictions about the structural degeneration of partnerships and, especially, non-hierarchical organisations rest upon economic prediction that NHOs are likely to unsustainable in the long term because they are in specific ways 'inefficient'. These economic analyses predict economic inefficiencies from: the absence of equity in the sense of saleable shares; members' economic behaviour; and from changes in the scale or composition of production. These are the predictions, mentioned above, which follow from applying the neo-classical economic theory of the firm to NHOs and partnerships.

Absence of saleable shares was predicted to cause four inefficiencies. First, members who contributed more to an NHO than they were paid would be locked into the NHO through being unable to sell their equity. Our findings falsify both the assumption and the prediction. The phenomenon of people wishing to leave an NHO or partnership but being prevented by equity 'lock-in' was never reported in our case study sites. The systematic review found (many studies) that NHOs which require an initial subscription from new members frequently make it partly or fully recuperable. Employees of corporations firms also typically have no equity in them but that is not usually regarded, at least by neo-classical economics, as economically deleterious. As for the prediction that the absence of share prices removes disciplines for efficiency, we found in our case study sites both the absence of share prices (though in partnerships the value of equity substituted for share price in this respect) and the presence of alternative disciplines for efficiency. (Competition for income or the imposition of standard national contracts provided an external discipline on the prices NHOs or professional practices could charge. Within these organisations, members' (or partners' mutual scrutiny of each other's work was an internal discipline on quality. Our systematic review found that the productivity of cooperatives was on balance higher than corporations in same sector in many instances. However there were also (a smaller number of) counter-examples. For partnerships, competition for income, especially competition from other

kinds of organisation, provided an external discipline on prices. So although the body of relevant evidence is somewhat equivocal, on balance of evidence it is against this prediction too, Our combined evidence (tends to support, but with qualifications, the prediction that the external sale of equity causes a degeneration of (i.e. is incompatible with) the a partnership or NHO. Our case study organisations avoided dependence on external share capital by raising finance for buildings (and in one case business 'goodwill') by setting up a dummy parallel PLC. Against this, our systematic review found many studies describing how the external sale of equity led to the degeneration of an NHO, and many studies reporting that it did not in the case of partnerships. We therefore conclude that the above prediction is valid for NHOs but not for partnerships. Lastly it has been predicted that NHOs will lack access to capital, hence be under-capitalised, due in part to the absence of equity release to members. Of our case study sites, two partnerships and two NHOs (all in the health sector) set up parallel companies to work around difficulty of accessing capital, a difficulty partly due to the liabilities which the English legal system places upon partners (but not to the same extent on NHO members). Of our case study NHOs, five had planned equity disposal should they fail. We found no evidence that lack of earlier release inhibited long-term investment. The (ex-cooperative that we studied was not demutualised in order to release equity, but to resolve a local impasse resulting from a change in health policy. However, many studies in our systematic review report how demutualisation was used as means to release accumulated equity, supporting the assumptions that equity release and NHO status are incompatible. Our systematic review also confirmed (many studies) that producer NHOs, especially small and medium sized ones, have lower capitalisation than corporations in same sectors). However these studies do not generally report that this lower capitalisation is due to being unable to release equity, nor that NHOs have a shorter investment horizon than corporations. There is also a conceptual difference between low capitalisation (which might indicate high not low cost-effectiveness) and under capitalisation (compared with some other normative benchmark). Published studies rarely if ever reported under-capitalisation of partnerships. The prediction that members or partners allocate surpluses to themselves rather than reinvest them was partially supported. In the provider organisations where we made case studies, members or partners did indeed pay themselves generously by local labour market standards. However, there was no evidence that this caused damaging under-investment. In consumer NHOs it was managers rather than members who took investment decisions, and they did re-invest surpluses. The members of these organisations were of course unpaid. The systematic review found evidence from Yugoslavia during 1980s, but not elsewhere, supporting the prediction of high pay and low investment. The review also (found reports that during the 'shoe-string' phase of setting up the organisation, members sacrifice their personal income in order to build up the NHO. Many studies in the systematic review reported that partnerships form mostly in knowledge-intense sectors requiring little

investment for efficient operation. Members' or partners' economic behaviour was also predicted to cause economic inefficiencies. For instance it was assumed that NHOs and partnership would be attractive to, hence recruit, workers of low competence or conscientiousness. We found no evidence to support this assumption. Our case study organisations usually recruited new members or partners competition or after a probationary period (standard recruitment methods in commercial and public hierarchies too). Once appointed, members or partners were subject to mutual scrutiny, peer pressure and ultimately expulsion if they proved lazy, incompetent or undisciplined. Similarly, our systematic review found (many studies) that NHOs and professional partnerships had 'concertive control' mechanisms for detecting and expelling 'free riders'. Cooperatives and partnerships with a 'representative' structure also applied the usual hierarchical controls to prevent it. Our findings suggest that due to these mechanisms the 'free-rider' predictions which neo-classical micro-economics dwells upon have little empirical applicability. Lastly we note the dearth of empirical, or even theoretical, studies comparing free-riding in cooperatives, partnerships and corporations. For consumer NHOs, the equivalent prediction might be that consumer 'irrationality' causes 'mission drift' so that the organisation produces inefficiencies. No such tendency was observed in our case study sites. Indeed small retail co-operative's consumers were ahead of market trends for 'green' and vegetarian consumption. Against this, many studies in the systematic review reported how in pursuit of capital gains members voted for demutualising financial NHOs. Different economic analyses have predicted that the expansion, the reduction and a change in product mix will each cause an NHO to revert to a corporation. We observed growth of production and of the study organisation in all but two of our case study sites, without consequent 'degeneration'. Systematic review evidence, (mostly from central and eastern Europe, suggests that when NHOs merge or undertake joint enterprises with corporations, or involve external financiers, 'degeneration' tends to follow. The corresponding evidence about professional partnerships comes mainly from Canada, UK, USA and is fairly evenly balanced on this question. As for the opposite prediction (the 'self-extinction theorem'), only two of our case study NHOs had a declining market share. There were signs of 'degeneration' in only one (OverThere), occurring because it responded a declining market share by mimicking corporate managerial practice. We therefore conclude that a shrinking market share can lead to 'self-extinction' but this consequence is not automatic. Papers in the systematic review described a number of declining organisations but attributed the NHOs' decline low capitalisation, dis-economies of scale and high wages, and the partnerships' decline to competition (e.g. from corporations). In neither case was their decline as described by the (self-extinction theorem. We had no declining partnerships among our case studies. Product (or service diversification was reported in four of our NHO study sites, but degeneration in only one (OverThere; see above). Substantial diversification occurred in one partnership, without consequent degeneration. Our systematic review

included studies of NHOs in which diversification had caused a hybrid structure to develop when diversification occurred though the absorption of corporations (a few studies) but seldom otherwise (many studies). Any of the aforementioned micro-economic predictions would imply that markets select against NHOs because the latter are 'inefficient'. Our findings conclusively show that the prediction that markets select against NHOs is not universally true. One of our case study organisations had competed in markets for over 50 years, two for over 100 years. Our systematic review (many studies) found that NHO failure rates are higher than for corporations in first five years but thereafter comparable. Waves of NHO failures in eastern Europe and Africa occurred when governments implemented World Bank and IMF marketisation policies against supporting NHOs.

12.4.4 Patient experience

According to our case studies, members of consumer NHOs mostly tend to occupy the lower rungs of Arnstein's 'ladder' of participation (343). Consumer NHOs found that routinised collection of administrative data created more usable and persuasive feedback than did patient groups, annual conferences or open Board meetings. The systematic review confirmed that only small minorities of consumers participate actively in the governance even of consumer, let alone producer, NHOs. In professional partnerships in the health sector, the quality of doctor-patient relationship important to both parties. English primary care general medical practice partnerships generally attained high GPPS and QOF scores although it is difficult to interpret what these scores mean for non-medical partnerships. Many published studies confirm that continuity of care, in particular relational continuity, is valued by patients and professionals. The review and our case studies corroborate that patient groups appear to be of limited value for obtaining patient feedback and patients' experiences of health care.

13 Conclusions

13.1 Answering the research questions

In summary we answer our original research questions as follows. On organisational environment:

1(a) What are the goals (explicit and implicit) of such organisations and why/how are they established? Their goals are to secure for members and partners and income no worse than prevailing market rates; produce a quality of work befitting their members' occupational status: to provide services for a particular locality: to break even (not maximise external shareholder profits); and to realise other values, including cooperation or professional values for their own sake.

1(b) What is the nature of the governance and incentive arrangements that are placed on these organisations from external bodies? Is there an effective form of regulation, and if so what is the nature of this? The main external governance mechanisms are contract and regulation. Contracts (work most effectively when their terms are specific, unambiguous, legitimate (in the providers' eyes) and strongly incentivised. To preserve NHOs' organisational structures against the weakening ('degeneration') of members' or partners' democratic control, alternatives to financing by external shareholders are required, and regulations limiting the proportion of (non-voting) salaried employees. As to organisational structures:

2(a) What are the structures and internal organisational arrangements of non-hierarchical organisations and partnerships? How are professional partnerships and non-hierarchical organisations co-ordinated, and what makes for a successful co-ordination strategy? (Partnerships' and NHOs' organisational structures essentially take either of two forms: a direct democracy of small workplace teams (which can articulated in multiple layers for controlling a large organisation); or a representative democracy in which the workforce elects the top, but not middle, managers. Optionally there may be a supporting infrastructure of employed staff. Successful coordination relies primarily on concertive control. Members or partners monitor each others' work and through peer pressure prevent shirking.

2(b) What are the key elements to the internal management of such organisations? In partnerships and provider NHOs they are concertive control as described above; legitimation of collective decisions by appeal either to an organisational culture or to technical knowledge; and as a last resort expulsion of non-compliant members. The internal management of consumer NHOs is undertaken largely by employed managers.

2(c) How do professionals within such organisations interact with each other and how do they regulate themselves? Through direct democracy, peer pressure and the use of technical knowledge as described above, but in larger partnerships a distinct stratum of manager-professionals may emerge. 2(d) How do such forms of organisation impact on securing professional engagement? Professional engagement in these organisations is promoted by high pay; by the organisation's decisions and activity being important for the professional's work taken as a whole; by enabling contact with fellow-professionals; and by providing a well-organised support infrastructure. Turning to production processes:

3(a) How do such forms of organisation impact on clinical workloads, job satisfaction and morale? They tend to produce an upward shift in the expertise and skills of their members and partners, which tends to satisfy members' and partners' intrinsic (i.e. non-instrumental, non-financial) motivations to work. In that respect they tend to increase workload, and add a managerial dimension.

3(b) How do such forms of organisation impact on the development of innovative practice? The forms of innovation which they favour are innovation through extensive replication, vertical integration, diversification and 're-engineering', provided that these innovations sustain the quality of work which the members or partners undertake, and maintain the members' or partners' centrality to the productive process. As outcomes, how do such forms of organisation impact on:

4(a) Clinical quality and development of best practice? NHOs and partnerships generally prefer to develop and market services and products on the basis of quality rather than price. The combination of evidence-based knowledge, incentives and concertive control appears to raise clinical quality.

4(b) Adherence to external performance targets? In the NHS both partnerships and NHOs are demonstrably capable of close adherence to external performance targets when these targets are clear, specific, legitimate (to the providers), incentivised and compliance (or not) is transparent.

4(c) The cost-effectiveness of service provision? There is sometimes tension between requirement to break even and the goal of raising quality of work. External competition provided a discipline to control costs, EBM a discipline for clinical effectiveness. On balance, micro-economic predictions that NHOs and partnerships are economically inefficient and unsustainable were not supported by the evidence.

4(d) Patient outcomes/experiences? (User participation mechanisms may have merit as a means of representing users in NHO and partnership (governance but the character of user experience was more effectively monitored and managed by developing systems for routine data

collection on that point. Because of their founding goals and membership, NHOs and partnerships were active implementers of evidence-based medicine.

13.2 Qualifications and limitations of the findings

An obvious empirical limitation to the case study findings is that we have had to make qualitative generalisations from relatively few cases, although we do have evidence for thinking that, in terms of user experiences, our health sector partnerships were fairly typical of the English NHS. Our case studies of partnerships omit some sectors (e.g. advertising, consultancy, vetinary practice) where the partnership model is widespread. Our case studies of NHOs omit agricultural, housing, industrial and transport producers. Because we could not attend such meetings our knowledge of partnership meetings was limited to participants' accounts after the event. Our systematic review was largely (though not entirely) limited to material (in English, by-passing much material on NHOs which appears to exist in the French, German, Dutch, Spanish, Italian and Hebrew literatures especially. Although we placed no limits of date or journals in our search of the literature, the dispersed, fragmentary nature of this literature leaves open the possibility that we have missed isolated peer-reviewed studies. We also note the possibility (we are aware of no studies on this point) that publication bias affects organisational as it does clinical literatures: successful organisational innovations are more likely to be published than failures. Our use of economics papers was limited to the minority with empirical content, although it might be argued that this is a merit not a weakness of the review. Our evidence about the economic characteristics of medical partnerships rests heavily on US research which, whilst generally of high quality, presupposes very different health system contexts to that of the NHS. Methodological limitations of the study are noted above.

13.3 Research recommendations

Our evidence also exposed questions in which further empirical research is warranted. (Here we list them in what appear to us to be descending order of practical, empirical and theoretical significance, noting which of the above evidence these recommendations arose from. Although implications for organisational research more widely also arise, here we limit ourselves to health sector research.

Our evidence (see ch.11s3, ch.12s1, ch.12s4,ch13.s4) shows up the lack of direct head-to-head empirical comparisons between partnerships, NHOs, corporations and PCTMS provision of services in terms of patterns of innovation, outcomes (in terms of QOF, GPPS and similar national data sets), price of services to commissioners, composition of costs, transaction costs and incentives for productivity (or, negatively, susceptibility to 'free-riding'). Because of the APMS contracting policy and the necessity to provide out-of-hours services, NHS primary care appears to offer a suitable

field for such comparisons. However to facilitate such studies and obtain greater organisational research value from the QOF and GPPS datasets generally (see ch.4s4), it would be necessary to supplement these datasets by recording (the contractual and organisational status of each NHS primary care provider. Assuming most NHS primary medical care will pro tem continue to be provided by GP partnerships, and assuming that the mean size of these partnerships will continue its slow growth, it is necessary to resolve the ambivalent evidence (ch.5s3, ch10.s2, ch12.1) about whether, at what size, and under what conditions economies of scale can be realised in primary medical care, for instance in the emerging GP-led health centres (of which London SHA have commissioned an evaluation). Such a study might also shed further light on whether, and under what conditions, the organisational structure of a professional partnerships does indeed converge upon that of a non-profit hierarchical social enterprise. As GP partnership size continues to grow, governments extend the NHS quasi-market into primary care and GP partnerships undertake health care commissioning, it would appear necessary to research the implications of these trends for the roles of managers in GP partnerships, and the nature and extent of the tensions between professional and market cultures. This is another point on which existing evidence is sparse and ambivalent (ch.5s2, ch.9, ch12s2). Since some PCTs seem likely to become social enterprises, it would be worthwhile researching the (specific size, and other conditions, at which an elected CEO and board becomes a more effective way of organising a non-hierarchical organisation than direct (relational) democracy (and vice-versa) (see ch.6.2, ch.9s1). Although this is not a recommendation for an applied research project, our combined evidence (ch.12) also suggests that neo-classical micro-economic analyses of the firm often lack empirical realism when applied to NHOs and partnerships. That necessitates the development of more realistic micro-economic models of these organisations.

13.4 Policy and managerial recommendations

Because they bear upon vested interests and competing normative standpoints, policy and managerial recommendations about the merits and demerits of partnerships and NHOs compared to other organisational structures, and about whether or how to conserve or develop NHOs and partnerships, are liable to be controversial. All that can be done is to make explicit - so that the reader be forewarned – the additional normative assumptions which transform 'implications' of research into 'recommendations'.

13.4.1 Professional partnerships, non-hierarchical social enterprises and the NHS

From the above evidence and conclusions it appears to us that compared to corporate provision, partnerships and non-hierarchical organisations offer as providers the following potential advantages to the NHS:

1. They pursue goals (quality of care as defined by professionals; professional engagement; collaboration rather than competition with similar providers; commitment to a particular local population or care groups; professional ethics; and in the case of consumer organisations, user control) which are closer to current NHS policy goals than those of corporations. Consequently when commissioning NHOs and partnerships there is less need for commissioners to rely on incentive schemes and the adroit formulation of contracts to produce this goal alignment artificially (and not necessarily reliably) than when commissioning corporate providers. Because of closer goal alignment one would also expect the public accountability of partnerships and non-hierarchical organisations to be easier to maintain, although that will depend on how far each organisation's specific goals happen to align with current health policies. Because of their structure, even 'degenerate' consumer NHOs are almost certain to be more accountable to the users of their services than corporations are to theirs. If general practices and cooperatives of NHS or ex-NHS staff count as 'NHS organisations' there is to that extent a foundation for the policy of regarding NHS organisations as 'preferred bidders' (see Health Services Journal 24th September 2009).
2. Their tendency to have goals that focus on localised constituencies creates a presumption that NHOs (and to a lesser extent partnerships) are likely to have strong local networks for inter-organisational collaboration and good local knowledge.
3. Their focus on localised constituencies and (especially in partnerships) their members' technical interests implies that a quasi-market with a predominance of professional partnerships and NHO providers is likely to generate diverse models of care and hence a 'requisite variety' of innovations, provided that commissioners can identify and select for development those which best match NHS objectives. To that extent, partnership and NHO structures would appear to facilitate innovation, but a more incisive question is what kinds of innovation. Our evidence suggests it is likely to be innovations which raise the professionally-defined technical quality of services and raise the skill level of professionals' work, rather than innovations for marketing or redistributive purposes.
4. Partnerships and NHOs tend to give priority to maintenance of income, security of work, and 'enablement' of working life for their members and partners, making them (in particular, cooperatives) the presumable organisational structures of choice for NHS staff should the policy of separating PCT-managed services from PCT commissioners be taken further.

On the other hand we found evidence that:

5. In cooperatives organised on the basis of direct democracy, decision making may be slower than in hierarchically organised providers, including corporations.
6. Corporations are capable of fast implementation of already-elaborated (but not necessarily newly-emerging) models of care, and of the management information systems required (208).

The empirical evidence was (ambivalent about the costs of care. Partnerships and NHOs tend to prefer to produce (what their members regard as) high quality services with relatively generous terms and conditions for members and partners. To that extent their services would tend to be costlier than those of corporations. Against this stands our evidence that professional partnerships and NHOs (except the large retailers) generally spend little on marketing, use less capital and of course avoid payments to external shareholders. Taken together, empirical studies in other sectors and countries give a no conclusive picture as to how these opposite tendencies balance out.

Here, however,

we are dealing with distinct institutional forms that differ in both their social structure and their patterns of authority. The issue is not merely whether one form of productive enterprise is more efficient than another, but whether one set of social relations and pattern of authority is superior to another.

(96); p.775

Non-hierarchical structures necessarily involve egalitarian, democratic control by their members but member control and member ownership are not the same thing. Member-controlled NHOs can be (and have been) state-owned (97). This raises the question of when of whether NHS hierarchies might be wholly or partly converted into NHOs.

13.4.2 Commissioning, competition and governance

Our evidence about innovation suggests two respects in which NHS contracts with partnerships and NHOs should remain incomplete. First, sensitivity to local constituencies and variations in partners' and members interests appear characteristic of partnerships and NHOs. To allow the development of 'requisite variety' in innovations and service models would require NHS commissioning practice not to standardise too narrowly in its specifications of how health care is provided, provided that QOF, GPPS or equivalent standards are satisfied to an acceptable degree. Second, relational contracting is for similar reasons necessary, but necessary in order to accommodate, develop and harness different organisations' (partners' and members') particular interests and constituencies, not only as a way of making contracts more complete by informal means (353).

Without doubting the desirability of further refinement, we (and our informants) found that the present-day commissioning framework for general practices compared favourably with pre-2004 methods. Contract

monitoring and the supporting information systems 'QOF, GPPS, and PACT 'gave providers clear, concrete, practically useful feedback about what had been achieved, what deficiencies remained and what the provider had been financially rewarded for. Many informants thought (and the researchers agree) that the above indicators between them cover many of the most important aspects of general medical practice: clinical process (including prescribing) and outcomes, patient experience and satisfaction. The contracts monitored and rewarded matters legitimately of concern to patients, providers and government. These principles appear applicable to NHS services more widely.

The same applies to another principle implicit in the 2004 GMS contract. That is the division of payments to providers into two elements:

1. Partly or wholly performance-linked payments. This element provides, the evidence of the new GMS contract suggests, an incentive to raise service quality and comply with the corresponding targets.
2. Payments covering other inputs.

Because the first element has a ceiling and the second is fixed, such units of payment also give the commissioners a predictable overall ceiling for service costs (even if they previously under-estimated how close to that ceiling medical 'and previously dental - partnerships would come). Separate arrangements would then be needed to finance capital developments.

Our finding that partnerships and NHOs tend to safeguard members' and partners' incomes, working conditions and job security, and to prefer providing what they define as high quality services implies that these organisations may be at a price disadvantage in competition with corporations. Given the foreseeable pressures on NHS budgets, this finding suggests distinguishing two ways of reducing the labour costs of health services. One is by using less labour or a 'leaner' skill mix to provide a given service. In our opinion this is desirable. The other is by reducing pay, and conditions (reducing pensions was a powerful de-motivator, we found) for a given workforce with no other change in service provision. In our opinion, this is of dubious benefit even when the savings accrue to the NHS rather than an external recipient. On this reasoning, a rule stipulating maintenance of the equivalent to current NHS pay and conditions for workers in all bidders would focus competition between them on technical improvements in cost-effectiveness (i.e. the first kind of cost-saving) and away from the second, purely re-distributional kind of 'cost-saving'.

We found ways in which existing NHS regulations stymie service development. In our opinion an obvious implication is to revise these regulations placing all professional partnerships (medical, nursing, pharmaceutical, dental) on the equal footing of being allowed (technical competence and skill mix permitting) to provide services across these occupational divisions, including such activities as prescribing, certification of illness and death, and referrals to secondary services. This does not

imply relaxing the law or regulations governing the clinical competence of each profession. Similarly cooperatives might be allowed to become primary healthcare providers in their own right, not only as subordinates to general medical partnerships. One way to reduce the risks which capital investment posed for GPs who were equity partners in a conventional (unincorporated association) partnership, hence to make such investment easier, would be to encourage adoption of the Limited Liability Partnership model (cp. (354)).

A 'proof-of-concept' policy lesson can be drawn for the case of the US consumer cooperative. It is the feasibility of placing large commissioning budgets under the governance of an organisation of users. These members were governing their own subscriptions rather than a public budget but at US$2.6bn per year a larger budget than that of a PCT. It also shows the necessity, in that case, of the organisation employing the necessary epidemiological and other experts; that only a minority of patients are ever likely to participate actively in its governance; and that the threat of 'degeneration' through 'managerialisation' is ever present. Nonetheless, this case suggests that such a form of governance appears feasible for NHS commissioning bodies on the scale of a Primary Care Trust.

13.4.3 Organisational sustainability

Supposing that NHOs are worth retaining and developing (e.g. for the reasons stated above) our evidence suggests that the following policies and management practices would help sustain (prevent 'degeneration' of) their organisational structures.

1. Limiting the proportion of employees (as opposed to partners or members) to the number required for short-term marginal fluctuations of work. Even in the small cooperative described above a margin of 10% was sufficient.
2. Where existing or new members cannot provide the necessary investment, restricting the types, sources and conditions of fund-raising for investment, excluding sale of equity in favour of issuing bonds or taking loans. If equity must nevertheless be sold externally, one cause of degeneration can be avoided by selling only non-voting shares. The contrasting experiences of the Mondragon and Estonian enterprises together suggest the prudence of giving external lenders no representation on NHO decision-making bodies; hence, of taking over other enterprises 100%, excluding external financiers from the merged organisation. In sum, therefore,

cooperatives need start-up capital without giving control to the supplier of the capital. The government is probably the most likely source for such capital.

(117); pp.1451-52

3. Minimising salary differentials, in particular salary differentials for employed managers. The Mondragon evidence suggests that a differential of five times is sufficient to ensure the provision of

expertise and competent management in a leading European industrial complex.

4. Create, on the model of our large retailer case study, legally-binding instruments which define the roles any employed managers are to play, the limitations on that role and on pay differentials; and, in the interests of internal democracy and being a 'learning organisation' (214), guarantee freedom of speech.
5. Recruit and select managers who are normatively committed to the principles of cooperation and understand the potentially 'degenerative' effects of copying corporate management practices unthinkingly into non-hierarchical organisations.

Whilst partnerships do not, as explained, face the same problem of degeneration, the question nevertheless arise as to whether to tolerate or resist the tendencies described above of evolution towards the organisational structure of a hierarchical, non-profit social enterprise. In our opinion this is a more open question.

Our evidence suggests two implications relevant to current policy. We found weak evidence (from US settings) of economies of scale in the range 10 to 20 partners and few economies of scale above that size. Whatever other benefits they may bring, mergers to create partnerships above 20 partners or the creation of federated GP-led health centres or even 'polysystems' of over 20 doctors appear unlikely to produce cost savings in primary medical care from economies of scale. But the evidence is not strong, somewhat dated and comes from quite a different health system. The 'office managing partner' model (103) suggests as one possible organisational structure for such centres an enlarged, multi-site general practice in which each partner-GP manages one (of several) sites (clinics), in each of which a number of doctors work as salaried employees of the practice.

Recent policy announced the end of patient catchment areas and more open, competitive recruitment of patients to general practice lists. Our evidence suggests that partnerships and NHOs are reluctant competitors. Many studies (355-363) indicate the value of continuity of care to patients and primary care providers. It therefore remains to be seen what effect this change to practice lists will have, especially in under-doctored areas.

13.4.4 Managerial ideologies and practice: learning or copying?

We found that the normative ideological persuasion of their managers was a factor in the survival and development of NHOs. Managerial ideology comprises not only generic management knowledge but also specific normative attitudes for or against specific forms of organisational structure and the corresponding organisational objectives, managerial practices, incentives and reward systems. Our evidence (ch.6s4,ch9.s4) suggests that whilst the some of more technical aspects of managerial knowledge may be

transferable between public, private and third sector, uncritically transferring corporate managerial practices and attitudes from corporations into partnerships and NHOs without considering what adaptation or restraint may be required in their new setting can produce - and in some organisations has produced - adverse results. In large professional partnerships outside the health sector:

Sometimes managing partners and other members of the executive will be impatient with this [egalitarian, loosely-structured] approach, e.g. they may favour more autocratic methods and argue that they are more efficient. They may be efficient where the majority of equity is in the hands of the few, but they are likely to be counter productive where the equity and power is more widely distributed amongst partners.

(86); p.848

In NHOs and partnerships there is therefore a far-reaching practical difference between learning (intelligently adapting) and copying corporate managerial assumptions, attitudes and practices. On that basis, our opinion is that the criteria for managerial recruitment into the NHS should include not only possession of knowledge of management in other sectors, but also an intelligent understanding of its limitations for NHS use. In the absence of hierarchical methods of control, managerial development methods of team-building, facilitation and assertiveness training appeared particularly valuable in non-hierarchical organisations.

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Appendix 1 Case studies

General Practice with Pharmacist Partner ('PharmPlus')

PharmPlus is located in a relatively affluent rural area. It is contracted under a PMS contract with additional monies for meeting QOF targets and providing additional services and dispensing medication. This income is used to finance its main practice and two sub-practices, premises, salaries and GP drawings. In November 2008, the practice was successful in bidding for an APMS tender for a practice in a nearby town and two new partners were admitted. Total patient numbers remain stable at around 6,300, fluctuating +/- 5 per cent each year.

PharmPlus is one of the few medical general practices with a pharmacist partner. Its partnership board currently consists of six partners: - three full-time, one three-quarter time and two on half-time (one of which is the pharmacist partner). There are currently 19 partnership shares shared in line with working-time status (3x4; 1x3 and 2x2=19). The pharmacist partner is viewed as equal to the GP partners on all levels except title. It is usual for new partners to be placed on a fixed share partnership contract until their contribution to the overall practice accounts can be established. This also permits a detailed examination of the capital accounts of the business and from this the cost of a new partner share can be established.

The Board is managed internally by a 'Chair of the Day' This is rotating position on an annual basis. All partners (except the pharmacist) take the role in turn. The Chair works closely with the Practice Manager and co-ordinates issues and changes. It is suggested that one of the problems with a professional partnership as opposed to a limited company is that all partners have different ideas and this sometimes means a 'multi-headed boss' Interviews indicated there was sometimes a problem with open communication between the partners especially with levels of workload. Some partners ensured they undertook only what was required and were not prepared to do any additional work, whilst others were. When seeking to admit a new partner, existing partners examine the pros and cons of increasing the partnership size. Affordability is the main issue.

Although strategic decisions are made by the partners in closed meetings, the Practice Manager co-ordinates the day-to-day running and financial affairs of the practice. At present, this post is filled by a former bank manager. Whilst the practice is committed to delivering the best possible patient care, it is careful to manage budgets. The Practice Manager sees the practice as a business. Until recently, the NHS was viewed as having 'a bottomless pit of money' and as this is not now the case the practice has re-thought its internal structure as an independent business contracted to

the NHS. All practice activities are tightly linked to QOF oriented outcomes. It is suggested that at times the practice is more money than patient oriented. For example, a minor cut used to be stitched at the health centre, but as the practice receives no QOF income for doing so patients requiring minor stitching are now referred to the local minor injuries unit.

Operating alongside the Practice Manager is an Operational Manager. At present this post is filled by a member of staff who has worked in various non-medical positions in the practice over a number of years. The Operational Manager deals mostly with staffing issues. This includes ensuring all GP surgeries are covered during periods of leave. Both roles have been expanded during 2009 following the acquisition of a new surgery and the amalgamation of those staff into the PharmPlus practice. There are now approximately 30 non-medical staff working in the practice over four sites. It is suggested that the increased size makes it more difficult to co-ordinate activities without a defined management structure and the introduction of teams with line-management reporting.

There is a non-partner bonus scheme available to all practice staff. This is viewed as an incentive and is tied to QOF outcomes. This differs fundamentally from the existing Christmas bonus scheme that simply rewarded length of service to the practice. Individual scores are now collated and sanctioned by the partners with reference to Practice Managerial input.

In 2006, a patient user group was established. This now meets quarterly and is chaired by the Practice Manager.

General Practice with Manager Partner ('PlusPM')

PlusPM practice serves a quite densely suburbanised part of the home counties. Its patient list is just under 11000. Neighbouring practices wish to increase their own list size but are not seen as a competitor in practical terms. PlusPM employs a practice manager, practice nurses and administrative staff. It provides its own computer and patient records system, and operates from medical centre with a building and equipment typical of general practices. All these resources are owned by partners (though not in equal proportions). Clinical care is provided by GPs, nurses and one receptionist (dual-)trained as a phlebotomist. Its main change during past three years has been implementing extended working hours for GPs. The practice introduced a nurse practitioner, who saw few 'normal nurse patients'. The nurse practitioner wrote around 20 prescriptions a day, thereby reducing the prescribing workload of GPs who otherwise would had done that prescribing. The practice opted out of responsibility for its out-of-hours services but against this central targets have increased its workload.

This practice is unusual in having made its former practice manager a partner or a similar footing to the GPs, though with different remuneration. The manager partner represents ('leads' for) the GPs in managing the

practice manager, who in turn line-manages the nursing and general administrative staff. This was described as a 'soft hierarchy', one reason being the mechanisms in place for staff to feed feelings or opinions up to partners. Another was the general consensus of support among the staff for the practice's stated objectives, set by the partners and PCT, of providing high quality general practitioner services. Practice meetings were used to discuss and implement all substantial changes in services, and for problem-solving. Practice meetings are used to enable proposals to be made, and there is a suggestion box for patients.

The partners regarded performance against QOF and other contractual targets as critical because it increased income, but saw no contradiction between that and the practice's own objective of increasing quality of care. Although key difference between this practice's structure and most others' was in having a manager as a partner, and there was little to suggest made any material difference in securing professional engagement. The point was strongly made by a GP that he and his colleagues were exhausted by successive reorganisations in general practice due to government policy, seeing no point them, especially practice-based commissioning. The GPs felt uninterested in what the PCT wanted to offer. They clearly felt that clinical workloads had become too heavy in general practice now, and hence their job satisfaction and morale appeared low. Yet senior partner also firmly stressed that the practice is motivated by providing a good service even if NHS policies are doing little to bring that about.

PlusPM practice was now working more closely with nearby practices due in part to practice-based commissioning, although they were sceptical this activity had made much difference. The practice was concerned about meeting its performance targets. Partly this can be explained by financial considerations, such as with QOF money, but the practice manager remarked how the relationship with the PCT has gone downhill recently, describing them as more difficult'than what they were.

The cost-effectiveness of service provision did not seem a salient problem for the practice although extra paperwork has come with the new systems for showing that QOF targets are being met, and that may not necessarily be compatible with cost-effectiveness. The practice gave much priority to staying within its prescribing budgets. Patients had shown little interest in a patient participation group that was set up, although the practice did run annual surveys in which patients are invited to submit comments. This feedback was reasonably positive and complaints by patients were at a low level, although the methods for discovering patients' opinions about the performance of the practice were not particularly systematic.

Nurse-led General Practice ('NurseLed')

NurseLed was a nurse-led partnership which very explicitly identified itself as a social enterprise. NurseLed wanted in some respects to model itself on the bigger, longer-established Bromley by Bow social enterprise.

In its present form the practice originated when, shortly before the start of the present project, the three GPs running the health centre retired. They had been operated the practice as a family-oriented GP surgery for 20 years previously. On their retirement the PCT put the practice services out to tender. The contract was won by three nurse practitioners who had previously worked the practice and bid in collaboration with a local social enterprise, a community transport company. Initially the partnership worked as a subsidiary of the parent social enterprise, under an APMS contract. Initially the PCT made the contract was with, and transmitted payment via, the parent social enterprise.

The latter therefore undertook payroll duties and oversaw the practice company finances. They were also consulted for employment and health and safety issues. They gave financial support and bought the practice premises. NurseLed was the only health service within the group of enterprises which made up the parent social enterprise. The practice's stated main goal is to remain a caring practice and put patients, rather than money-making, first. The practice was also committed to a policy of team working and reduction of traditional hierarchies. Nonetheless the two nurse partners appoint and expel staff, including in the past two GPs (one for being too cautious in approach and the other not a 'team player'). The practice policy is that staff must be team players and able to work autonomously in small unit. As far as possible decisions were made by consensus of all staff. No practice manager was employed to oversee day to day operations. Weekly staff meetings voted on proposals suggested during the previous week, but in these discussions more weight was given to staff who would be undertaking the tasks being discussed or changed.

The NurseLed building was owned by a parallel limited liability company whose directors were the practice partners and a representative of the parent social enterprise. No other GP practices in the PCT were run as social enterprises.

The practice had 20 staff on contract, but most were only used temporarily or part-time to cover when more regular staff were absent. Two sessional GPs worked five days a week and three regular nurse practitioners between them worked two sessions every morning and one every afternoon. All these staff were salaried. The PCT made up any shortfall between the practice's expenditure and its contract income. Despite employing sessional GPs, the practice partners were nurses with the philosophy that 60%-70% of patients coming to the surgery were best dealt with by a nurse practitioner. The GPs were encouraged to restrict themselves to seeing more complex cases freeing NPs to undertake general consultations. All staff were involved in keeping and updating patient records.

Some patients left the practice list when the previous long-established GPs retired but the practice list soon stabilised at around 4300. The internal regulation of the quality of practice services was via patient satisfaction surveys and peer evaluation of clinical work. Its PCT set guidelines for GP

surgeries under QOF framework, and applied them to NurseLed practice too. Service users provided feedback on services, in part through a patient participation group.

The practice foresaw a growth of its patient list and changes to funding and control regulations. The directors planned to take over the lists of local practices falling vacant and put out to tender, and so run more surgeries. They anticipated the practice would need to move to bigger premises to accommodate this growth.

Private Architectural Partnership ('Architects')

Architects is an architectural partnership based in London which employs circa 80 people. It has been in business since 1938, and followed the standard model of architectural activity for a large, city-based firm until the 1950s. It then made a deliberate policy of becoming involved in all architectural matters to do with healthcare, developing the 1950s equivalent of a mission statement' that it would produce the highest quality architecture and run a successful business.

Over the past twenty years, the practice has changed significantly. It still occupies its original office premises, but has acknowledged that to run the business successfully, it is no longer sufficient to train as an architect, nor even to employ adjunct quantity surveyors and structural engineers. Increasingly, this professional profile has had to be supplemented by more professionally trained business staff.

As a result of the group's close relationship with healthcare projects, it has also been affected by wider changes in the public sector, and in particular by the advent of the Thatcherite policies towards the professions, and three decades of the New Public Management. Thus, the group found itself in a much more competitive situation, with a distinct change in the market place as a result of the insurgence of North American architectural practices into the UK market. These North American practices tended to be larger and more integrated in respect of marketing, financial, business planning and support services. Added to which, the past reliability of repeat business from the public sector had evaporated. Also, within this market there is further competition in the form of the need to now develop bids against scale fees rather than using a 'cost plus'system.

Against this background, the group felt that it may be getting out of its depth in respect of its non-architectural skills and capacity. It was also becoming increasingly necessary to change its management processes as the system was 'Creaking'in such a complex and demanding market. The group's solution was to merge with another European architectural practice to form a pan-European strategic and operational partnership and alliance.

The merger has brought immediate benefits to the group with a dramatically improved profile, greater global exposure and a sense of being taken more seriously. The group also feel that they have chosen the right

partners to merge with as the new group is a very stable organisation and one which shares the same ethos, namely that it does not become over-commercial, is still committed to the public sector, and is still 吐ascinated'by the healthcare sector, providing, as it does, many and varied professional challenges to professional architects. The new partnership offers particular benefits in terms of HRM and a differentiated scale of training opportunities for new staff who join the group. The group plans to stay with bidding and designing for middle size projects of £5-20 million.

Structurally, from 1938-2001, the group was a full professional partnership with equity partners. From 2001-2007 (up until the merger) it became a limited company. There were originally four equity partners, each of whom had the same financial share but not the same levels of responsibility. When the group changed to an LLP, it had seven shareholding directors which then went down to five shareholders before the group merged with the European partnership. The main professional body which the group is influenced by is RIBA (Royal Institute of British Architects) and the governance of the Architects Registration Board. Members are also part of other bodies, especially sustainability and green organisations related to architecture as well as the Urban Design Group.

The current arrangements give the original group a minority shareholding in the new partnership. The group members do not feel that they have lost control as a result of the merger; in fact they felt that they were losing more control when trading as a single partnership because the sector had become so complex with many new projects in the health sector (e.g. pharmaceutical practices) becoming more engineering than building design led. The group's original size also made them vulnerable to an uncontrolled takeover.

In terms of the division of labour in the firm, it strives to have as flat a structure as possible, but in reality, it is semi-hierarchical, built around a team structure per project with a director per project. There are also sector based teams, e.g. for health or education. This can lead to some issues and some difficulties when marketing to other sectors, and some directors are better at client -facing business than others.

The organisation of activity very much matches the actual architectural process in terms of the inter-connecting stages, which are : Inception; conception; design; production and delivery. However, changes in the external environment, particularly in respect of professional regulation, have meant that some of the traditional division of labour has had to alter. There is now a much heavier monitoring and quality control process that has meant that monitoring as a whole new skill area has had to be overlaid onto the traditional mix of design, technical and contract activity. Unless all these activities are presented in a fully integrated format to the clients, there is the danger that the client may in turn become dissatisfied, interpreting a lack of integration as a lack of true interface with themselves.

This could also be seen as a bifurcation of the professional client architect relationship.

There were some telling comments from the MD of the group 'namely in respect of the incursion into the UK market by large American healthcare integrated practices who were seen as being on the same side as the contractors' so indicating an alteration (under this model, at least) to the professional relationship and trust dynamic between the architect and client.

The changing nature of this fundamental relationship is further represented in other co-ordination and decision-making processes within the group, particularly what was described as the 'Huge shift'in how the company relates to other organisations. The original model of partnership-client relationship (Figure 1) has not been possible to recreate under the more complex conditions that are seen in Private Finance Initiative (PFI) projects where, from the architect's perspective, there are multiple clients and agents to the extent that the architects are often left asking "Who is the client?'(Figure 2).

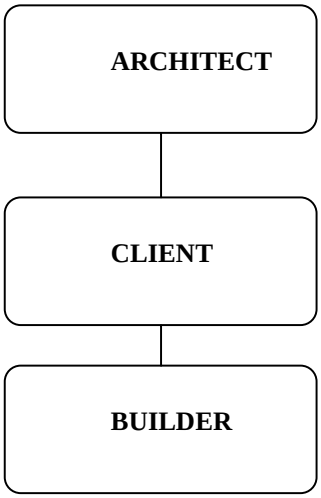

Figure 1. Traditional architect-client relationship

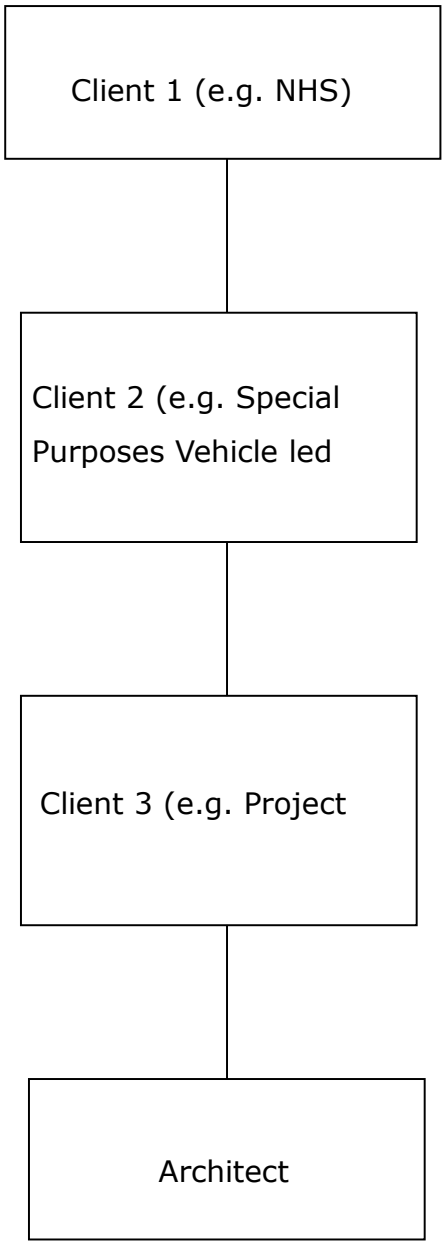

Figure 2. Architect-client relationship in PFI

These changes to the group's previous core activities are further exacerbated by the requirement for the group to work in an ever increasing number of consortia and groupings of other architects and to put together sets of multi-disciplinary teams in order to bid for projects. Thus, the professional standing of the architects has been pushed down the hierarchy in this multi-client, multi-agency model. This not only adds to the complexity of the project in terms of communication and diffuse decision-making, but also in respect of commerce as the attenuated hierarchy has reduced the overall amount of fee income which is available.

Whilst not a term used in any interviews, this description is akin to that of a supply chain. One of the corollaries of which has become the increasing

need to indemnify the professional practices of the contributions in the consortium. The key dynamic which has changed is that of trust, and the MD of the company expressed this as trust in all its different versions' The old trust relationship which bound the simple tripartite relationship together has been replaced by one based upon performance 'and, indeed, a concept of performance that is not always fully articulated, nor jointly decided.

One of the consequences of this, is that some of the architects believe that they are spending time on activities other than what they are trained for, particularly in respect of marketing. Some of the architects' practices are being forced out of business by increasing competition and the financial consequences of the increasing corporatisation of architecture. It is felt that good and innovative design still sells, but practices have to work in a different way now with many practices focussing on particular sectors. Architects' work is 60% public sector, which they believe demands yet a further set of skills. But, repeating earlier points about the environment, the biggest competition comes from the USA where practices are highly trained in marketing and have a much more focussed sales techniques, whilst also being process and business driven.

In summary, although the practice has been in business for many years, they now exist in an extremely volatile environment with the need to look at changes in their organisation. This is seen as being difficult and means addressing the attitudes of senior staff who mostly have quite disparate attitudes towards work. The overarching key outcome is to run a successful business at a profit and to have new and repeat clients and a professional peer group that is satisfied with the company's design and approach to projects.

Private Accounting Partnership ('Accountants')

Accountants International is a network of legally independent firms, all of which carry the Accountants brand. In the UK, it is structured as an LLP 'limited liability partnership - the liability of the members being limited to their capital in the firm. This structural solution is influenced by the demands of modern corporate governance and the need to be fully corporately transparent. The firm has taken this approach to be an independent, strong and viable firm, deliberately positioning itself below the four major accountancy and consulting firms. The structure was also influenced by the opportunity to limit the exposure of members of the LLP and to facilitate recruitment by creating rewarding professional careers in order to ensure that clients receive the best service. Externally, the firm is heavily influenced by the regulatory needs and requirements of the accountancy profession. There are two types of partner: salaried partners who have no investment; and equity partners, who are members of the LLP.

The current structure came about in 2005 and involves a constitution incorporated in a Member's Agreement. The LLP structure has meant that the firm has a much more commercial focus and corporate outlook although

the pre-existing partnership ethos, prior to the LLP structure, has allowed further cohesion and shared decision-making in the firm. The sense is that now the firm is even more integrated financially. Prior to the integration in 2005, there was local retention of profits by the associated firms but now there is one central profit centre.

The principal activity of Accountants (UK) LLP is the provision of assurance and advisory, taxation, financial planning, management consulting, corporate recovery, corporate finance and forensic services. The key environmental determinants are the regulatory requirements of professional accountancy. There are competitors who form part of this external environment, who operate with a similar range of services, but with a different balance and mix of work.

The regulatory elements to the firm's activity come from the FSA, professional financial institutions (e.g. ICAEW, CIMA, ACCA) and the government. Compliance and quality assurance is expected by the regulatory bodies, but given the position and seniority of the firm, a dialogue is maintained with the regulators.

Competitors form part of the external environment, but at the same time they are also a group of people with whom a dialogue is maintained 'particularly the Group A firms of leading accountants. The nature of competition is manifested in terms of clients, resources, staff, prestige and market position. However, Accountants has differentiated itself within this competition such that there are some clients it would leave to other companies on the basis of risk exposure, but also in terms of the relevant experience base. The market comprises a large range of clients from the very largest companies (say, top 100 listed companies) to smaller unlisted companies 'but the real competition is in the middle, especially for Accountants in terms of the owner-managed business sector. Thus, by taking a highly selective approach based on value and quality, but above all the appropriate technical resource base, the firm has focused its attentions on those sections of the marketplace which it is best equipped to service.

The firm is organised on a regional basis, each with a managing partner who all report to the national managing partner. Added to this, there are also some national heads of departments for services such as corporate recovery and forensic financial services. The decision-making approach is narrowly focussed - not diffuse, and has led to an efficient management of the firm, with a high level of consistency. This is important, as the LLP structure has meant that the operational decision-making and governance of the firm has changed. Previously there was a council which acted as the custodian of the firm's values. This has now been superseded by a new board with four elected and three non-elected members. Some of the LLP members have a management role and some have technical roles, but like many senior executive structures, their roles involve the exercise of judgement and expertise.

Critically, from an external view, the firm is seen as a solid, large organisation, with a reputation for quality service delivery, which demonstrates its core values. These values mean that it is seen as a different, friendly, more approachable firm than some of its competitors, close to its clients internally and externally, and with a team atmosphere. The aim is to grow the business organically but not necessarily to discount the option of growth through merger.

The size and diversity of the client group and the good cultural and competitive employment package contribute towards Accountants being seen as a good place to work in the competitive market place of professional financial firms. There is a graduate recruitment scheme and Accountants seeks to differentiate its offering from the top four accountancy firms by offering staff a broader business experience, early initiative and independence in their careers, and a very structured technical and professional training programme.

The performance which is expected of staff is made explicit, and consequently it is understood that staff know what is expected of them. Performance is articulated around five key drivers:

1. producing good quality work
2. serving clients
3. growing fees
4. being commercial
5. leading and enabling people

These criteria are employed throughout the firm. There is an employee survey and enablement survey in operation which helps to assess the direction of the firm and how staff can contribute and be recognised. There are also a series of staff conferences used to gauge the effect and impact of change in the company, and levels of motivation. The model of partnership which the company operates is also designed to operate as a retention tool for staff with the ultimate possibility of becoming an equity partner.

In respect of authority and how it is exercised, there is a high level of responsibility concentrated in the roles of managing partner, regional partners, and heads of department.

Legal Partnership [Legal]

Legal is a private legal partnership based in an rural region of England. It has office representation in the four largest regional towns. Although each office is treated equally, there is a consensus amongst staff that one site acts as a quasi-head office. The watershed in the partnership history appears to have been the merger of two earlier partnerships in 2000. During the merger, the newly formed partnership decided to adopt a more corporate (co-ordinated) organisational form. A formal partnership deed was set up that structured the business in such a way that it now had an

elected management board, rather like a company board. The Board currently comprises six partners including a Chair. Only full equity partners (currently 17) can both stand for nomination to the Board and vote on partnership matters. Since 2000, Legal has merged with a number of smaller legal partnerships in order to have full regional overage. Their stated partnership aim is to become the biggest and best private legal partnership in the region. Legal has a streamlined, cross-office corporate management structure. An elected management board chaired by an elected partner board member oversees the strategic direction of the firm. The Board also includes a designated senior partner (who deals with external liaison) and a managing director who is responsible for the day-to-day management of the firm and for successfully implementing the firm's business plan. The managing director is supported by non-lawyer professionals who have responsibility for the operation of support departments. These include: Business Excellence, Business Development, Facilities, Finance and IT. The main professional bodies which the legal partnership is influenced by are: The Solicitors Regulatory Authority and The Law Society.

In terms of the division of labour within the group there appear to be two distinct populations. From the bottom-up the hierarchy is structured thus: paralegals, legal executives, assistant solicitors (comprising anyone who has just qualified right through to someone who is 4/5/10 years qualified), above them are associates (usually 5 or 6 years qualified). Above them are limited equity partners. Limited equity partners share profits in the business but haven't invested capital. Above them are equity partners. These partners have invested capital in the business (currently £200,000 each) and they share profit between themselves.

As a consequence of post-merger growth in both staff and client numbers, Legal has moved into new office space in all 4 locations. The office space is ultra-modern 'a deliberate act in order to attract and retain clients as well as highly motivated and trained professional staff. The main changes expected during the next five years are the outcomes of the recent Legal Services Act. At present, partner capital is fixed. This means that the amount of capital a partner invests is the amount that is withdrawn when the partner leaves. Partnerships thus struggle between allowing maximum drawings or ongoing capital investment. From 2011, the Legal Services Act will enable partnerships to operate to a corporate model. They will be allowed to become a company and have limited liability with holding companies. Within these companies capital value can be built.

Primary Medical Care Cooperative ('Metro')

Metro Out-Of-Hours Services is a not-for-profit cooperative limited by guarantee. It was established in January 2004, by the amalgamation of three earlier, similarly-structured cooperatives: Since December 2004 its services have been commissioned by three contiguous urban PCTs to

provide out-of-hours services to over 900,000 patients. In addition its sister organisation, a PLC, has been working alongside Metro in providing services such as cover for out-of-hours training.

However during the course of the research Metro lost their largest out-of-hours contract to a corporation from another region. Thus Metro is having to explore different avenues of work. It is currently undertaking a pilot exercise with the practice base commissioning consortia, a PCT and hospital trust to develop supported discharge. Even if this were successful, it would not recover the out-of-hours work lost and redundancies are on the horizon. Even though Metro is a not-for-profit social enterprise is does have operating reserves and any redundancy payments would have to be met through this source.

GPs working in the three PCTs that Metro serves are able to become members of Metro OOH Services. The only criteria are that they must have an 'active commitment' to the organisation. However, 'active commitment' was not defined. Although it is expected that members work out of hours, if they later cease to work out of hours but remained committed to the organisation in 'Some way' they can remain members. Other staff members such as nurses, drivers and telephone operators are employed directly by Metro.

As its structure the organisation has a Board of Directors, which comprises GPs elected to the Board. Any GP working for Metro can be nominated to the board. The PCTs also have an input to the board.

One of the biggest issues facing Metro prior to loss of their OOH contract was cost. All respondents suggested a concern with costs appeared to permeate through all operations. There was a call to use more nurses in order to reduce the cost of medical staff whilst at the same time retaining the same levels of service. Hourly paid nurses were cheaper than doctors, said to be better at telephone triage and had also been undertaking less complicated home visits. It was not uncommon for staff to multi-task on the same shift. For example, if Primary Care Centres were full and telephone triage staff quiet, it was expected for them to help out and see patients on a face to face basis. On the flipside, if doctors were quiet, but telephones busy then doctors were expected to the help given by triage staff. Monetary objectives (in the form of performance targets) were set by the PCTs.

Communications between members were made via regular (usually weekly) e-mails to members. Any significant information was also sent by post to member's home addresses. There is an AGM and regular members meetings. The AGM is seen as adherence to statutory requirements and formal business is discussed. Members meetings are less formal. These deal with issues such as clinical governance and premises issues.

Medical Cooperative ('City')

City has for its members approximately 500 GPs in a non-for-profit limited company set up in 1996. It is owned, managed and financed by the GPs and now represents GPs in three contiguous city boroughs. It is a members'cooperative. Initially an on-call cooperative, it now offered a wider range of medical services including: primary care locum services, 24-hour answering services and forensic medical examiners. Legally, however, City was only legally obliged to offer out-of-hours services so its name was changed to reflect its new core activity.

City is owned and managed by GPs who have opted into the out-of-hours care provided by City. If their surgery uses City, they automatically become members (owners). However, to work as a GP for City, individuals need to be either a partner GP, or a salaried GP working at least six sessions per week in their own surgeries. Initially, GPs were expected to commit to working a certain number of hours for City per month, but as the number of members has increased, there is a waiting list to work. Each GP is paid £120 an hour for out-of-hours work.

The division of labour within the organisation is semi-hierarchical. It comprises: Company Secretary, Council Members (including Board of Directors), Chief Executive, Finance Manager, Operations Manager, Supervisors, GPs, Non-medical staff.

City is democratically controlled. The GPs for each of the three boroughs has five council members per borough, one member of whom is each elected to serve on the board. Each is re-elected after two years. The council has bi-monthly meetings where policy and staffing issues are discussed. The CEO views the strength of City as its members. The GPs provide the out-of-hours service and how they do that is up to them via voting rights at members meetings. By being members of City they can dictate how the service is delivered and for what cost. There appears to be ambivalence from older GPs about attending membership meetings. At the last AGM, only 30 GPs (approximately 5% of the membership) attended.

Competitors form part of the external environment, and there is a competing corporation working in a nearby borough. There is also increasing pressure from newly created drop-in 24/7 clinics.

The membership of City are regulated by the General Medical Council.

City does not own its premises. It currently has four consulting rooms at a community hospital, for which it pays rent although the hospital is now being rebuilt under the Private Finance Initiative (PFI) and on completion, City's rent will increase to £250,000 per annum. City is therefore seeking cheaper premises in a central location for patients within a 2-3 mile radius. It's long term vision is to work in a multi-team building (one-stop-shop) that may incorporate other services such as social services. This would

allow for fuller utilisation of all assets and allow greater flexibility of decision-making.

Consumer-led Cooperative ('OverThere')

OverThere is a non-profit health-care system based in the USA that integrates care and coverage. It serves more than 600,000 members in two states, it one of which it is one of the largest employers with over 9,000 employees (including nearly 900 doctors). It offers both individual and group insurance plans.

The organisation is managed by a Board of Trustees who are officially charged with establishing organisational goals and setting policies. The Board works closely with management and medical staff to ensure that the policies and strategic direction puts patients first. However, in practice the Executive Leadership Team (ELT) (management) often seem to initiate goals which are then legitimated by the board.

There appears to be three loci of control within the organisation:

1. The cooperative (culminating in the Board of Trustees);
2. The management (culminating in the ELT);
3. The medical professionals.

Members do not automatically become voting members. They must register their need in becoming so. However, this is a simple process which involves no fee or special health requirement. At present there are approximately 30,000 voting members out of 175,000 potential members. Often there is a delay between a new member joining and registering to become a voting member. Voting members later vote for individuals to join the Board of Trustees.

The Board currently comprises 11 members including a chair. The official aim of the Board is to oversee and monitor the well-being and accountability of the organisation by a variety of tasks including: establishing organisational goals, setting policies and monitoring fiscal affairs.

Below the Board are various consumer, leadership advisory and focus groups. These groups feed upwards and are thus officially placed within the 'cooperative governance structure' but may be more accurately described as tools for user feedback, rather than user governance.

The Management Executive Leadership Team (ELT) has various executive divisions including a health plan division, strategic services and quality, public affairs and finance. The medical professionals have executive teams that feed into the ELT.

As for Medical Professionals, every clinician has to serve a 3 year probationary period before they are elected into the organisation. A key

element to 'passing' probation is the receipt of a large number of high scores for patient satisfaction. This is an attempt to make the organisation more primary care-led. Physicians may describe a democratic way of working but in reality there are tight hierarchical organisations operating in local medical centres. The biggest change over the last three years has been the pilot and subsequent introduction of its 'Medical Home' model. This endeavours to provide out of hospital care with an emphasis on prevention and self-care of chronic conditions. It also utilises an interactive web tool which is described as being 'beyond the medical record' This has been through a process of continuing development and now allows the patient to order prescription items, view lab results, make appointments and review consultations with their doctor. This information is further supplemented by DVDs. Despite this, membership appears to be declining. During 2006, membership reduced by 27,000. OverThere is viewed as being too slow to respond to changes desired in the healthcare system.

The medical home model has led to dramatic changes in the way doctors work. As a consequence, they clearly have a reduced patient list size and this in turn offers greater positive changes for their home life. The key clinician mentality appears to be that of 'Serving others'rather than 'Get rich' and emphasises preventative medicine.

Cost-effectiveness appears to be behind many of the introduced innovations. However, here, 'lean management' appears to be about expanding the organisation whilst cutting out wasteful practices.

Organic Food Cooperative ('Wholefood')

Wholefood and a like-minded bakery ('Likebakery') with which it collaborates both sign up to the Statement on the Cooperative Identity (adopted by the International Co-operative Alliance in 1995) (itself founded in 1895) which defines a co-op and sets out its underpinning principles and values. Cooperatives themselves are constituted under the Industrial and Provident Societies Act.

Likebakery Grocery is a worker cooperative owned and run by its workforce, currently in excess of 40 members within the 10,000 sq.ft. premises. It is a flat-rate pay organisation making all decisions by consensus. From a turnover of £3,500 to £3.5 million, from 4 members to 50, Likebakery donates 5 per cent of wage costs to local and international projects. It opened in a large northern city in 1996 and it now owns 21 acres of prime growing land 14 miles from its shop. It is able to stock over 70 lines of organic fruit and vegetables grown in the area. It also sells a selection of environmentally friendly baby products, cosmetics and household goods. The shop is full of information about the source of the products so consumers can make informed choices in their purchasing.

Likebakery follows on from a model devised in 1980s and used first at the Daily Bread Co-operative, Northampton. This model involved direct, often

bulk purchasing, on site processing and competitive margins and prices. This was run by owner- members following a clear social agenda.

Wholefood Cooperative is a democratically run, worker-controlled business. Its constitution demands the promotion of the physical, mental and spiritual well-being of the community, especially of those individuals participating in the cooperative. It consists of a cafe and shop where all the products are vegetarian or vegan and fairly traded wherever possible.

The above also cooperate with the UK's largest independent wholesaler-distributor. It specialises in vegetarian, fairly traded, organic, ethical and natural products. It is a radical workers' cooperative, having dedicated 30 years to providing quality products with unparalleled customer service.

Competition is now increasing as large supermarkets are campaigning to show their green credentials. All three cooperatives have a division between full members, probationary members and staff. The movement from latter to the former is encouraged, but for Wholefood this is partly about responding to increased demands during student term times when they employ part-time 'Staff' for short periods of time in order to cope with increased demand. Only full members can vote in all three organisations. The large wholesaling cooperative has an elected management committee but no Chief Executive and motions can be raised by any member. Likebakery and Wholefood operate via a consensus so they need all members to agree on major decisions. They are also divided into teams. Likebakery's teams send elected representatives to a fortnightly meeting called: 'The forum' The purpose of 'The forum' is to undertake shorter term strategic decisions. The whole membership meets every quarter. Decisions require 100 per cent approval, although members may also abstain or voice reservations whilst withholding objections. For a proposal to fail it needs to be blocked by at least two out of the forty members. Strategy and policy is set by all three organisations in general membership meetings.

Individual members join all three cooperatives due to a mix of ideals 'political, philosophical, spiritual etc. They are also attracted to the ideals of democratic working and the absence of hierarchy. In the wholesaler in particular, people enjoy a multi-skilling environment. Often this is because they have worked for other organisations and have loathed the hierarchical or corporate ethos.

All three cooperatives pride themselves on multi-tasking, so there is a mix of manual labour, office labour and driving by members. However, all employ committees or teams to tackle more specialist work. These teams are not permanent, but in Wholefood, the treasurer has been in post for over 6 years (as the smallest cooperative they may have problems with replacement).

Mutual Building Society ('HouseLend')

HouseLend was founded in 1853. In 1942 it merged with a nearby building society and acquired its present name. Since 1962 and 1987 several other building societies have merged into it, most recently in 2009. HouseLend is a mutual building society with its head office still in its provincial town of origin. It has a nationwide branch network across the UK.

The society is owned by its members. Individuals can become members by having savings or borrowing in excess of £100. In the case of joint savings / borrowing the first named on the account becomes the member. Each member has voting rights at the AGM. In a sense, the society is owned by its members and this accountability appears to drive much of what the society does. There were approximately 900,000 voting members in January 2009, but only 40-50 actually attend the AGM in person. The AGM is used as an opportunity not only to meet statutory requirements but as a key channel to communicate what the society is doing in terms of priorities and key issues.

However, despite the society being owned by the members the best members can do is to get the board to consider a request. The Board is bound by statute to act in the best interests of both current and future members. If they feel that members are suggesting a motion they consider to be not in the current or future interest of the society it can be dismissed at board level after consideration. A recent example was a motion that the society de-mutualised. This was rejected by the board.

The Society is bound by the rules of the Financial Services Authority and also regulated by the Building Societies Organisation (BSA). In accordance with Building Society Association control of balance sheet regulations at least 75 per cent of its assets must be invested in retail mortgages and at least 50 per cent of funding must come from retail customers. Against the current financial turbulence, the FSA asks for twice daily balance sheet checks. Internally, it is governed by its directors who work under its own rules and regulations. It has 19 sub companies which include an estate agency and credit reference agency.

The society appears to have adopted a deliberately flat hierarchy comprising: Executives, Non-Executives, Regional Mangers, Branch Operation Managers and Customer Service Staff. The setting of objectives is led by the management team in consultation with members. The building society undertakes two common activities: 1.) It completes financial transactions on behalf of branch customers and 2) by staff employed by a financial services subsidiary it sells various financial products.

The motto of HouseLend is 'Mutual Matters' Staff are continually reminded about its four objectives: Enthusiasm, Fairness, Ownership and Trust. A 2008 marketing campaign sought to differentiate HouseLend from corporate banks and de-mutualised building societies by highlighting the fact that HouseLend tries to do the best for members and not shareholders.

Marketing campaigns cite the removal of all security barriers in branches and staff-customer interaction is determined to be a 'conversation with a purpose'. A key mantra is: 'attract on price and retain on service.'

The society undertakes its own in-house training. Every new member of staff completes two four-day training sessions at the head office within the first three months of joining. There is no graduate training scheme but the society has its own 'academy' an internal training scheme for customer service staff who have the ambition to become branch managers. There is also the 'Famous Academy' for existing branch managers who have the drive to become regional managers. As well as this in-house training, staff are assisted with their professional qualifications (such as mortgage accreditation) by the Learning and Development Department. All staff are expected to qualify at advanced professional levels.

Large Retailer ('Bigshop')

This cooperative is a unique retail organisation designed around a set of principles and values. Its uniqueness lies in its founding purpose to provide 'Happiness for its members through worthwhile and satisfying employment in a successful business' Since 1929 it has been owned by a trust for the benefit of all who work in it. It is a profit-making retailer but there are no outside shareholders. Net profits can be used as the partnership so deem, including to fund an annual partnership bonus as well as for re-investment in the cooperative. These decisions are taken by a Partnership Council which represents all Partners. The details presented in this case, and the interviews which were conducted during fieldwork are from one city centre store, but the business principles which are described apply to the whole cooperative in the UK. The local environmental issues are specific to the case study which is presented here.

In order to understand the culture and operating principles of the Partnership, it is necessary to understand the power of the principles and how these are reinforced in every aspect of the cooperative's and employee activity. They are:

1. Be honest. Partners will be open, decent and fair. The Partnership will maintain a climate of transparency and trust.
2. Give respect. Partners will treat others in the way they expect to be treated. The Partnership will guarantee a fulfilling working environment.
3. Recognise others. Partners will value others'contributions. The Partnership will ensure a fair reward for all.
4. Show enterprise. Partners will seize the initiative whenever possible. The Partnership will give Partners the freedom to use their talents.

5. Work together. Partners will work together for the benefit of the Partnership. The Partnership will provide a sense of common purpose.
6. Achieve more. Partners will strive to achieve greater success whenever possible. The Partnership will recognise and celebrate exceptional achievement.

Partners share the responsibilities of ownership as well as its rewards which are 'profit, knowledge and power'. A good sense of the nature of the cooperative comes from the Chairman's welcome to new staff printed in the Partnership handbook. This explains that the recruits have entered 'a special business and a different kind of place to work'. Thus the cooperative can be seen as the embodiment of an employee owned cooperative. The Principles are regarded as the DNA of the cooperative and it is they which serve to influence the cooperative's structure. In an interview with the store's managing director the Principles were described as a 'line coiling' in and around the structure.

Commercially, the cooperative is extraordinarily successful in respect of profitability, reputation and presence in the high street. However, it is also very clear about what it does and what its employees do, and to quote 'we work in a shop; our job is to interact with people and to sell to customers'. Staff join the cooperative for a variety of reasons - because they know its values, it can match and can improve upon the market rate for remuneration; has outstanding terms and conditions of employment and offers structured career opportunities.

Two levels of environment influence were identified 'the broader UK company environment and the immediate local, and in this case, urban civic environment. The cooperative environment also includes its supply chain. All products are nationally sourced via the Head Office operations, and there is some, but very little, regional or local variation in the range of products for sale. Hence the national distribution centre is regarded as a key environmental determinant, as are suppliers, buyers, and other non-competitive retailers. In this sense, the cooperative is remarkably resilient to broader environmental forces because of its sense of corporate unity that serves to create its own environment. None of the respondents spoke of the national retail environment, only their own cooperative environment and local civic issues.

Locally, the environmental interaction is with the local city council, particularly in respect of issues such as the quality of the local urban environment, traffic management; local transport initiatives; discussions about the effect of congestion charges on local retailers and the level of rents and commercial rates that are charged. The cooperative seeks to work in a collaborative way with the public services and to encourage a pro-city centre retail set of values and support from local policy-makers. One example of this collaboration is working with the police. The store is a member of 'retailers against crime' and is active and vigilant in respect of

anti-terrorism. Staff also work with special constables and community workers in schools and colleges. In turn, the cooperative seeks to influence the environment and have a strong voice in the city because they wish to attract a particular socio-economic category of customer and it is important that this type of customer finds an attractive local retailing environment. Community involvement also assists in staff recruitment. Other local environmental influences are the neighbouring retail forums and competitors with whom the cooperative benchmark themselves, but with whom they also co-operate particularly on local urban matters of joint interest.

Retailing is not an occupation subject to any specific regulation more than that which applies to the rest of commerce. However senior members of the cooperative belong to local retail forums, chambers of commerce and the city's business assembly. Thus, networks are more civic in their scale and tend to be used for lobbying and advice.

It is the cooperative's structure which has attracted the label 'unique'. It is held in Trust, with a Board of Trustees, and for the benefit of the membership. The cooperative operates via explicit democratic principles, has a written constitution, and operationalises this democracy using a series of councils and formally elected bodies to assist with the sharing of 'profit, knowledge and power'. The cooperative is proud of this democracy and its first 'staff council' was set up in 1919. There is a Partnership Council which represents all partners and it elects five directors to the Partnership Board which decides policy issues. Any partner can stand as a candidate for election to the Board, and elections take place every two years. Four-fifths of the members are elected, and one-fifth appointed by the chairman. Freedom of speech is guaranteed, and council members have a role that is clearly representational rather than to act as constituents or delegates for sectional interest.

Other aspects of the unique approach of the cooperative are the degree of explicitness with which they deal with working issues. In the staff handbook, one of the sentences is 'knowledge and power are linked'. Much of the responsibility for this knowledge-sharing is placed with managers who are told that they are constantly accountable to Partners, particularly via councils and their sub committees where managers have to account for their business performance. Even matters of business reorganisation and redundancy are discussed, such that the Partnership Board has to approve any reorganisations or closure involving the loss of 12 or more positions.

Much of the success of this democratic approach is as a result of the cooperative's structure, but also because of the design and effort put into communication. Every branch of the retailer and its support services has a Committee for Communication (C4C) elected by and comprising non-management Partners, and they have existed since 1915. Informal communication is also encouraged and reinforced to take place 'Constantly'

and further supported by regular meetings, written material, notices and bulletins.

In all the interviews, this 'uniqueness' of the resultant philosophy of an early nineteenth century social experiment was revealed. Furthermore, the uniqueness has been exploited to give the cooperative a commercially differentiated position in its niche area as a department store. This fosters the success of the cooperative and helps it to perpetuate itself by generating its own return, and protect it from 'carpetbaggers'. This culture of philosophical and business differentiation is actively and positively encouraged by including 'in every conversation discussions of how to do things differently'. The founding principles have not changed, only the language of these principles has been contemporarised.

The philosophy behind the organisational processes of the cooperative relates to the statement 'that we are a shop', the operating model is one of first principles 'they are not too complex 'we have sales staff and we organise them by function and the staff's job is to serve the customer and meet their needs if at all possible'. Twenty to twenty-five years ago the cooperative had a move to develop rules and regulations and standard operating procedures, but it became apparent that too much emphasis was being put upon these procedural ways of working. Today, the focus has shifted away from these procedural approaches, so 'releasing the potential of our people', allowing, once trained, staff to make their own judgements within the principles. The values and principles of the cooperative are instilled into every point of the staff recruitment with potential new staff being tutored about the ethics of the cooperative.

The outcomes for the cooperative revolve around sustaining it within the principles of its philosophy. Standard, commercial retailing outcomes are also fostered such as, cost control, costs as a percentage of sales, service levels and their achievement. There are Key Performance Indicators (KPIs), one of which is how quickly a product reaches the shelf in a cooperative that has over 300,000 product lines. These KPIs are expected to be met via the partners even where they do not have a direct responsibility for a particular process 'such as the central distribution system. Using this as an example, store partners would be expected to work with a distribution centre if there was a problem getting a product to the shelf and to partake in joint problem solving to develop a communication conduit in order to deal with operational issues.

This level of performance is appraised via the personal development plans of all staff, the plans are designed around achieving the Principles. The principles are set as the performance indicators, and the measures are set at three levels of 'don't want to see'; 'want to see' and 'outstanding', built around a set of behaviours about what partners are expected to do.

A Nationalised Medical 'Partnership' ('PCTrun')

PCTrun was a three-partner practice in a medium-sized but not wealthy provincial town where recruiting GPs was difficult. A few years before this study one GP, the senior (managing) partner reached retirement and plans for the succession had to be made. For family reasons the two remaining partners were uninterested in taking on the daily tasks of managing the practice and wanted to leave open their options for part-time work.

They therefore arranged to become salaried GPs employed by the PCT. The two GPs retained ownership of the building, renting it back to the PCT.

The PCT appointed an experienced practice manager to work full time on-site managing [PCTrun] practice. The medical staff complement was the three salaried GPs (part-time), a full-time salaried GP registrar and locums. Towards the end of the fieldwork another GP was recruited to work full-time. The PCT provided the locums, relieving the GPs of what had been a stressful responsibility since it was as hard to recruit locums as doctors. The practice manager was line-managed by a PCT manager. She did most of the work involved in re-negotiating the PMS contract for the practice, was clinical governance lead for the practice and managed the QOF side of its work. Nevertheless she did not regard herself as the GPs' line manager. She would raise task and problems in general terms at practice meetings, but did not direct the individual GPs. Indeed it was not very clear whether for practical purposes the GPs really had a line manager, although in the same way as partner-GPs they had an annual appraisal with an external appraiser. Certainly they felt that the PCT was in no way interfering with their clinical practice.

The main external influence of clinical work was through PACT data and the concomitant meetings at which each GP's prescribing practice was compared with that of other local GPs, but this arrangement was just the same as for a conventional partnership. The GPs met managers from the PCT infrequently but relationships between GPs and PCT were described as friendly. PCT decision-making seemed slow to the GPs. The GPs received a flat-rate salary with (to the GPs' regret) no performance-related element. They therefore wondered whether, after 2004, their pay was therefore falling behind that of partner-GPs in other local practices. As partners the GPs had equal incomes, but salary rates now varied between them.

Negotiating the practice's PMS contract with the PCT had been something of a revelation to the GPs, making them feel that the future of practice was less secure than once it had been. This raised a number of questions in the GPs' minds. One was whether their working hours might unilaterally be changed. Another was whether PCTrun practice might be merged with another (as had been proposed some years before but had not materialised). The biggest question was whether the practice might be put out to competitive tender. The GPs were aware of the controversy and outcome of the proposal (early in the fieldwork period) about putting a

vacant general practice in North Derbyshire out to tender, which an American corporation (UHE) had been awarded. Negotiating the contract proved difficult because it was a new contract being drafted from scratch, which took over a year until the BMA produced a prototype draft of its own, which PCTrun and the PCT adapted.

The PMS contract did not change the profile of services provided at PCTrun very much from those provided by or at local GMS practices (which were still professional partnerships). Neither did the new profile of services depart very far from what PCTrun had already provided. The practice had a nurse practitioner, practice nurse and four long-standing medical records / reception staff. A midwife and a CHD nurse visit the practice for one session a week (antenatal care and CHD care respectively) and there was a regular drug addiction clinic. The practice manager handled day-to-day staffing issues, staff recruitment, finance. She had also recruited a health care assistant to visit older patients at home. The PCT often helped with staff recruitment and selection, but at times the GPs did it themselves. (The practice was involved in a practice-based commissioning consortium, at which the practice manager would normally represent the practice.

Former Medical Cooperative ('WasCoop')

WasCoop is a PLC originating from the failure of a cooperative providing primary medical care outside ordinary working hours. It operates in a rural area with several small (but no large) towns and a correspondingly dispersed but often fairly well-to-do rural population in commuting reach of several cities. The large distances necessitated relatively high numbers of doctors and cars for out-of-hours work.

The cooperative from which the present owners and workers for WasCoop was recruited served one town and the surrounding countryside, with GPs contributing sessions in proportion to their practice list size. This in put was given in kind without any direct payment because at that time the GP contract required 25 hours a week per GP. The local GPs were initially reluctant to join in because of concerns about safety. Not all were interested or qualified in obstetrics. They joined the cooperative gradually, with the cooperative starting by providing night cover first. Initially the PCT provided call-handling infrastructure and nurses from the local minor injuries unit (MIU) to triage calls but as the MIU workload the nurses were withdrawn and triage work subcontracted to a corporation. This proved expensive and the firm had no local knowledge, resulting in what the GPs regarded as a poor service. The PCT had never identified or paid the costs of the cooperative's infra-structure, which meant the cooperative was continually short of money.

The 2004 GMS contract allowed GPs to opt out of out of hours care. To deal with the implications the PCT called a steering group including the chair of the co-operative and 14 other out-of-hours services providers who were also operating for different groups of GPs across the PCT's territory. The

group was 'messy to coordinate' and with so many conflicting vested interests made little progress towards agreement. After two or three meetings the chair of the cooperative suggested (outside the group) to the PCT link that the co-op chair and few colleagues organise a commercial service at a fair cost and good clinical standard. The PCT welcomed the idea but then had to undertake the due process of inviting tenders. The 'few colleagues ' were two other GPs from the cooperative and its administrator. As managing director for the new firm they recruited a manager which experience in a number of out-of-hours cooperatives who was now looking for a 'less bureaucratic' organisation to work in. Two GPs and this person own the business equally, employing the former administrator of the cooperative. Initially they employed salaried GPs to cover nights, but these were gradually replaced by partners in local practices, whose goodwill the organisation had largely retained, working sessions. Increasingly they have been supplemented with nurse practitioners (NPs). Formally the GPs are self-employed contractors paid a flat rate per session (increased for nights and the busy, less popular weekend slots). No NHS pension but the session payment is enough to cover it should the GP wish to pay out of that. There developed a flourishing 'internal market' in 'Selling shifts' The firm now employs call handlers, drivers, nurses and support staff. Although [WasCoop] was commercial they were proud of being good employers, with training and an ethos of support and open feedback.. But the sessional GPs were not employees and so the firm had no need to use formal disciplinary interviews and warnings to dispense with an under-performing or non-compliant GP. There was a largely medical forum with five elected GPs and the managers who meet every two months, to which the PCT sent its patient representative. The directors saw WasCoop as part of the NHS. They were sceptical about the idea of its becoming a social enterprise because it would then have to diverse interests, and so become slower, in its decision-making.

WasCoop had failed as a cooperative in large part due to the disorganisation of its PCT, which had under-funded it and allowed out-of-hours primary care services to remain fragmented and uncoordinated. The PCT's decision to encourage WasCoop to replace the cooperative was an ad hoc response to an unforeseen, unplanned event. The replacement company had the structure of a former professional partnership which had just crossed the threshold of transforming itself into a corporation. It now had a hierarchy of support staff (with the sessional GPs effectively causalised) managed for profit by three partners whose work had become much more that of an owner-manager than professional 'shop floor' production work.

Appendix 2 Electronic search strategy (Medline)

1. non hierarch$ organi$.mp. [mp=title, original title, abstract, name of substance word, subject heading word]
2. hierarch$ organi$.mp. [mp=title, original title, abstract, name of substance word, subject heading word]
3. nho.mp.
4. cooperative$.mp. [mp=title, original title, abstract, name of substance word, subject heading word]
5. exp Societies/
6. exp Social Welfare/
7. exp Cooperative Behavior/
8. exp Voluntary Health Agencies/
9. exp Professional Practice/
10. exp Partnership Practice/
11. hierarch$.mp. [mp=title, original title, abstract, name of substance word, subject heading word]
12. organization$.mp.
13. 11 and 12
14. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 13
15. exp models, organizational/
16. exp organizational culture/
17. exp Entrepreneurship/
18. exp Organizational Innovation/
19. 15 or 16 or 17 or 18
20. 14 and 19

Appendix 3 Electronic search strategy (Medline)

1. Reference ID:
Author

Type of organisation (by provisional taxa)
1. Professional partnership Y/N
(a) atomised Y/N
(b) collaborative Y/N
(c) other Y/N
For 'other', please describe what activities the individual partners undertake jointly.....

2. Non-hierarchical organisation:
(a) consumer co-operative Y/N
(b) producer co-operative Y/N
(c) voluntary organisation promoting policy Y/N
(d) voluntary direct service provider Y/N
(e) fundraiser Y/N
(f) Other Y/N
Please describe its main activities:

Coverage of hypothesised relationships
3. Factors covered (tick any that apply):
(a) environment of organisation Y/N
(b) organisational structure ('form') Y/N
(c) organisational processes Y/N
(d) organisational outcomes ('function') Y/N

4. Relationships covered (tick any that apply):
(a) Environment - organisational structure ('form') Y/N
(b) Environment - organisational processes Y/N
(c) Environment - organisational outcomes ('function') Y/N
(d) Organisational structure - organisational processes Y/N
(e) Organisational structure - outcomes ('function') Y/N
(f) Organisational processes -outcomes ('function') Y/N

5. Evidence base (tick any that apply)
(a) Census of organisations Y/N
(b) Survey of organisations Y/N
(c) Survey of individuals Y/N
(d) Multiple case study Y/N
(e) Single case study Y/N
(f) Observer, participant or managerial rapportage Y/N
(g) Internal 'grey' document(s) Y/N
(h) Other, please state.....

6. Representativeness (tick any that apply)

(a) Census Y/N
(b) Randomised sample Y/N
(c) Purposive sample Y/N
(d) Convenience sample Y/N
(e) Single report or case Y/N
(f) Other, please state.....

7. (Method (Tick any which apply)

(a) Randomised control trial Y/N
(b) Quasi-experiment (i.e. non-randomised control) Y/N
(c) Other comparative design Y/N
(d) Longitudinal (historical, before-and-after, time series) Y/N
(e) Multiple case study Y/N
(f) Single case study Y/N
(g) Laboratory game / simulation / experiment Y/N
(h) Other (please state).....

(a) Is this a multi-method study (e.g. survey + case studies)? Y/N
8. Publication Peer reviewed? Y/N

Include/Exclude decision

PP and or NHO? Y/N
At least one ESPO relationship covered? Y/N
Has at least one of the above types of evidence base? Y/N
Has at least one of the above types of method? Y/N
Peer reviewed publication? Y/N

Substantive Findings

Relationships found (summarise or enter 'N/A'):

1. How environment influences organisational structure ('form')
2. How environment influences organisational processes ('organisational behaviour')
3. How environment influences organisational outcomes ('function')
4. How organisational form influences organisational processes ('organisational behaviour')
5. How organisational form influences organisational outcome ('function')
6. How organisational processes influence organisational outcomes ('function')

Relationships to policy outcomes;

Which cell(s) in Table 1 does this study cover (tick any that apply)?

	Environmental factor	**Organisational Structure**	**Organisational processes**
1 Securing professional engagement			
2 Impact on clinical /			

professional workloads, job satisfaction and morale			
3 Impact on: 3.1 clinical quality and development of best practice			
3.2 impact on evidence-basing on practice			
3.3 development of innovative practice			
3.4 Adherence to external performance targets			
3.5 cost-effectiveness of service provision			
3.6 Patient outcomes/experiences			
3.7 Service access			
3.8 Range of services			
3.9 User opportunity to influence services			

Country and sector (tick any that apply; write in where necessary):

Does the study cover the health sector? Y/N

Does the study cover non-health sectors? Y/N

Which non-health sector(s)?

Main service(s) provided? (please list)

Main client group(s) served? (please list)

Which country / countries are covered?

UK Y/N

Other European (including former USSR) Y/N

Australia Y/N

Canada Y/N

Israel Y/N

New Zealand Y/N

USA Y/N
Other(s), please state

Appendix 4 Study site characteristics in GPPS data-set

	Metro	City	PCTrun	NurseLed	PlusPM	PharmPlus	England (mean)
Q37 - Are you male or female? [% female]	57	53	60	63	61	58	58
Q38 - How old are you? [% over 65]	29	21	35	21	26	36	31
Q39 - What is your ethnic group? [% other than British]	22	52	10	35	4	5	18
Q40 - Which of these best describes what you are doing at present? [% not in full or part time work]	50	44	59	62	52	45	50
Q43 - In general, would you say your health is? [% excellent or very good]	41	44	32	45	50	43	41
Q44 - Do you have any of the following long-standing conditions? Please include	50	56	43	52	59	48	51

problems which are due to old age.[% with no long-standing condition]							
Q46 - Are you a parent or a legal guardian for any children aged under 16 currently living in your home? [% yes]	23	25	22	30	27	11	22
Q47 – Do you have carer responsibilities for anyone in your household with a long-standing health problem of disability? [% yes]	10	9	13	8	7	12	9

Source: GPPS 2008 dataset

Appendix 5 Case study data grid

One column per organisation, row headings shown below:

Environment of the organisation

Policy context 'external policy imperatives which apply to this organisation

1. Legal and regulatory framework:
2. Professional bodies 'nature and extent of regulation of organisation members
3. External resource dependences and their institutional structure:

    (a) users (patients, clients or equivalent)
    (b) staff (including volunteers) (
    (c) money (all sources)
    (d) knowledge / information
    (e) legitimation i.e. legal/regulatory/professional recognition/permission
    (f) physical resources (equipment, consumables, accommodation)
    (g) others?

4. Stability of environment

    (a) main changes during past 3 years
    (b) main changes foreseen in next 3 years
    (c) in/stability of workload

5. Any similar organisations:

    (a) earlier, that anticipated (or became) the present organisation?
    (b) elsewhere 'non-competing
    (c) competing / substitute

6. Formation of organisation:

    (a) recruitment mechanisms and criteria 'open or closed organisation?
    (b) individual members' reasons for supporting the organisation
    (c) How members are lost / expelled (criteria, mechanisms)
    (d) Who provides (the above) resources and how

7. Objective setting 'what is the stated purpose of the organisation, its core activity and intended outcomes?

    (a) what objectives does the organisation have
    (b) who sets organisation objectives
    (c) by what processes
    (d) degree of consensus, support or opposition among organisation members for these objectives

Structure of the organisation

1. Membership ('stakeholders')

    (a) owners
    (b) electors
    (c) producers
    (d) users

2. Division of labour

(a) Managerial tiers ('vertical' division of labour
(b) skill mix ('horizontal' division of labour) organisational members
(c) roles of service clients or users (including proxy users such as carers)

3. Property rights

(a) who owns what resources
(b) incentives or sanctions

4. Coordination processes and who participates in each

(a) deployment of materials, staff?
(b) information (data) exchange?
(c) referrals?
(d) delegation of budgets / staff / decisions from higher-level decision-makers?
(e) joint learning / training / self-development /knowledge management
(f) information and monitoring systems

5. Trust, affiliation and conflict

(a) shared assumptions, beliefs, value 'organisation 'culture' and 'ideology'
(b) any conflicts or disputes, dissident members, active or passive resistance from any organisation members or groups thereof
(c) any soft coercion?
(d) How uniformly do organisation members participate in its activities?
(e) Incentives to collaborate and their effects

[Process]

1. 'Technology' by which the organisation undertakes its core activity i.e.

(a) nature of the common activities which the organisation undertakes (
(b) who directly interacts with whom, in undertaking this activity
(c) its resource requirements i.e. external resource dependencies above plus internal resources supplied by the organisation members. Same categories as above i.e.:

(i. users (patients, clients or equivalent) and their inputs*
(ii. staff (including volunteers) (
(iii. money (all sources)
(iv. knowledge / information
(v. legitimation / authority / permission
(vi. physical resources (equipment, consumables, accommodation) 'their asset specificity, nature and quantity (
(vii. others?

2. How changes occur in organisation's core activity 'openness to innovation

Outcomes of organisation activity

1. How organisation activities compare with:

(a) mandator's requirements (where applicable)
(b) organisation's own stated objectives
(c) member organisations and individuals' reasons for supporting the organisation
(d) SDO's original list of policy outcomes: How do such forms of organisation impact on outcomes in terms of:

i. Securing professional engagement;

ii. Impact on clinical workloads, job satisfaction and morale;

iii. Impact on clinical quality and development of best practice,

iv. The development of innovative practice;

v. Adherence to external performance targets

vi. The cost-effectiveness of service provision; and

vii. Patient outcomes/experiences.

Appendix 6 Selected GPPS scores for study general practices

GPPS item	PCTrun	NurseLed	PlusPM	PharmPlus	England (mean)
Q4 - How helpful do you find the receptionists at your GP surgery or health centre? [% fairly or very helpful]	95	92	98	94	84
Q15 - Is there a particular doctor you prefer to see at your GP surgery or health centre? % yes]	56	24	64	65	62
Q16 - How often do you see the doctor you prefer to see? [%Always, almost always or a lot of the time]	63	0*	86	70	77
Q17 - How satisfied are you with the hours that your GP surgery or health centre is open? [% very or fairly satisfied]	78	79	92	76	81
Q18 - Would you like your GP surgery or health centre to open at additional times? [% Yes]	55	58	47	58	55
Q20a - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at - Giving you enough time? [% very good or	94	82	92	98	90

good]					
Q20b - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at - Asking about your symptoms? [% very good or good]	93	83	92	94	88
20c - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at - Listening to you? [% very good or good]	94	82	93	92	89
Q20d - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at - Explaining tests and treatments? [% very good or good]	88	70	82	87	78
Q20e - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at - Involving you in decisions about your care? [% very good or good]	80	66	70	92	73
Q20f - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at - Treating you with care and concern? [% very good or good]	92	79	89	88	85
Q20g - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at - Taking your problems seriously? [% very good or	90	75	87	92	84

good]					
Q24a - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice nurse at - Giving you enough time? [% very good or good]	97%	94%	98%	94%	94%
Q24b - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice nurse at - Asking about your symptoms? [% very good or good]	92%	90%	83%	88%	83%
Q24c - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice nurse at - Listening to you? [% very good or good]	97%	91%	89%	92%	89%
Q24d - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice nurse at - Explaining tests and treatments? [% very good or good]	99%	88%	83%	86%	84%
Q24e - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice nurse at - Involving you in decisions about your care? [% very good or good]	86%	83%	69%	81%	75%
Q24f - Last time you saw a practice nurse at your GP surgery or health centre,	93%	91%	92%	91%	90%

how good was the practice nurse at - Treating you with care and concern? [% very good or good]					
Q24g - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice nurse at - Taking your problems seriously? [% very good or good]	92%	88%	83%	92%	83%
Q25 – In general, how satisfied are you with the care you get at your GP surgery of health centre? [% very or fairly satisfied]	97%	81%	95%	92%	92%
Q27 - In the past 6 months, have you had a discussion with a doctor or nurse about managing your long-standing health problem? [% yes or not wanted]	95%	94%	91%	95%	91%
Q28 - Following this discussion, did a doctor or nurse agree a plan about how you wanted to manage your long-standing health problem? [% yes]	91%	100%	84%	87%	85%
Q29 - Do you think that having a discussion or plan has helped improve the care you receive? [% definitely or to some extent]	94%	76%	87%	87%	87%

* *Data negligibly small, suppressed.*

Source: GPPS data 2008-2009.

Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.